Community Family Support/ State Personal Assistance Application

Date: _____

PART I – GENERAL INFORMATION				
Last Name		**First Name**		**MI**
Home Address (Number, Street)		**City, State**	**Zip Code**	**Parish**
Mailing Address (If different from Home Address)		**City, State**	**Telephone Number ( )**	
Social Security #	**Date of Birth:**	**Age**	**Sex: ☐ M ☐F**	**Marital Status:**

Race: ☐ **American Indian or Alaska Native** ☐ **Asian**
☐ **Black or African American** ☐ **Hispanic or Latino**
☐ **Native Hawaiian or Other Pacific Islander** ☐ **White**

What is your disability?	**At what age did you become disabled? (attach all supporting documentation to this application.)**
☐ **Cognitive** ☐ **Hearing** ☐ **Mental/Emotional** ☐ **Vision** ☐ **Physical** ☐ **Other** ☐ **Multiple Disability**	

PART II – DISABILITY AND RELATED MEDICAL INFORMATION

*****Additional information may be attached to or written on the back of this form.*****

What independent living service(s) are you applying for?

	Yes	No
Are you capable of selecting, supervising and if needed, firing an attendant?		
If "NO" could you manage your own attendant if trained to do so?		
Are you capable of managing or directing others to manage your own financial and legal affairs?		

Assistance required for activities of daily living.

	Ambulation		Transfers		Administering Medications
	Bathing		Shopping		Bowel, Bladder or Other Bodily Functions
	Grooming		Consumption of Food		Food
	Dressing		Housekeeping		
	Communication		Meal Preparations		

Which of the following reason below are you applying for service?	
	Exit nursing home or other institution
	Avoid nursing home admission
	Enhance employability

Are you receiving Medicaid services at this time? Have you applied for the EDA Waiver, NOW Waiver, or LTPCS? If so When did you start receiving these services or when did you apply?

☐ Yes	☐ No	Who provides care? (e.g. family, friend, etc…)

Residential Settings

When applicants or consumers present attendant care system breaks down, who is available to assist? Do they live with applicant, have frequent contact, or would provide care "*now and then*", "*in emergency*", etc…?

Does consumer have need for daily medical treatment? (e.g. catheterization, sterile dressings, name of medication, dosage and frequency)

Employment

☐ Volunteer Work	☐ Employed part-time	☐ Employed full-time
☐ Retired on disability	☐ Employed in competitive employment	☐ Employed in sheltered employment

Seeking Employment? ☐Yes ☐ No ☐ Full-Time ☐ Part-Time

Sources of Income Check sources of income. (If salary, show amount of wages after insurance, retirement, taxes and FICA is withheld.)

☐ Social Security Disability Income (SSDI)	☐ Rehabilitation	☐ Insurance
☐ Supplemental Security Income (SSI)	☐ Wages	☐ Family/Spouse
☐ Worker's Compensation	☐ Other	

Gross Monthly Income: $

Other Means of Support (housing assistance, food stamps, ets.)

Applied for Medicaid ☐ Yes ☐ No	Medicaid Number

Eligible for Medicare ☐ Yes ☐ No A_____ B_____ C_____	Medicare Number

Part III - PERSONAL & EMPLOYMENT INFORMATION

List other persons living in your household:

Name	Age	Relationship	Describe any disabilities (if applicable)

Name two (2) people who do not live with you and who will know your address if you move:

Name	Address	Telephone Number

PART IV – ADDITIONAL INFORMATION

Does the applicant receive any of the following services?

☐ **SSI Aged** ☐ **Veteran's Disability**
☐ **SSI-Blind** ☐ **Other Disability**
☐ **SSI-Disabled** ☐ **SSDI**
☐ **AFDC** ☐ **Other Public Support**

Indicate your main source of support:

☐ **Self** ☐ **Spouse**
☐ **Family** ☐ **Public Assistance**
☐ **Other_____**

Do you have health insurance coverage?

☐ **Yes** ☐ **No**

Comments:

Independent Living Specialist Comments:

Upon intake of this consumer, I, _____, Independent Living Specialist, do agree that this individual meets the criteria of having a disability.

Independent Living
Explanation of Rights and Responsibilities

YOUR RIGHTS:

- To receive assurances that all information relative to your independent living program will be held confidential and will be used only insofar as it affects your ILP in accordance with Section 361.49 of the Rehabilitation Act, as amended, regarding Protection, Use and Release of Personal Information, and Agency policy and procedures.
- To have such information released only with your authority or written consent.
- To schedule an appointment with your Independent Living Specialist at any time during your Independent Living Program to discuss any problems or concerns.
- To request, in writing, a review when a problem or concern cannot be resolved between you and your Independent Living Specialist.
- To avail yourself of the services of the Client Assistance Program (CAP) and to request involvement of the Client Assistance Program if you encounter problems that cannot be resolved to your satisfaction, CAP can be reached at 1-800-960-7705 (voice or TDD) or at 1010 Common St., Suite 2600, New Orleans, LA 70112.
- To know that refusal to provide requested information could affect your eligibility for services.
- To know that vocational, medical, and/or personal information about you may be shared with other agencies, such as the LA Dept. of Labor, Education, Social Services, Health & Hospitals, Public Safety & Corrections; colleges & universities; local school boards; Social Security; and doctors/hospitals/other medical & rehabilitation professionals who provide services for you through the Southwest Louisiana Independence Center, Inc.

YOUR RESPONSIBILITIES:

- To assist your Independent Living Specialist in gathering information needed from other agencies or individuals to determine your eligibility.
- To provide accurate information and keep all scheduled appointments.
- To provide any requested information/records pertaining to your disability and information/records pertaining to your ability to participate in the costs of services.
- To use services/funding for which you may be eligible from any other source(s) to assist in the cost of your independent living program.
- To actively participate with your Independent Living Specialist in planning to develop and implement your Independent Living Plan (ILP) that will outline your independent living goal, expectations, and needed services. The delivery or implementation of any service(s) listed on my ILP is (are) conditioned on the approval and signature of both myself (and my authorized representative), my Independent Living Specialist, and any supervisory or other agency approval(s), as well as the availability of funds.
- To contact your Independent Living Specialist if you believe your ILP should be changed or if you have any other concerns regarding your ability to complete your ILP and obtain independence.
- To put forth your best effort in completing the objectives outlined on your ILP.
- To follow recommendations related to your program, such as taking medications, participating in therapies, etc.

DISCRIMINATION PROHIBITED: You will not be discriminated against on the basis of race, color, creed, national origin, sex, disability, and/or age in the determination of eligibility and/or provision of independent living services.

I hereby apply for independent living services.

_____ _____

Signature of Applicant/Parent/Guardian/Advocate **Date Signed (Month, day, year)**