

**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
ATTENDANT SERVICES PROGRAM APPLICATION**

A. Instructions

Before you fill out this application if you are not currently enrolled in Medicaid (or have not recently been denied Medicaid and Choices for Care) you need to apply for Medicaid eligibility. Please call 1-800-479-6151 or visit http://dcf.vermont.gov/esd/health_insurance to obtain a Medicaid Application.

1. Fill out this application if all of these apply to you:

- you are 18 years or older, AND**
- you have a permanent and severe physical disability that affects your ability to perform Activities of Daily Living such as bathing, dressing, walking, AND**
- you are able to direct your own attendant care services and do not have a legal guardian.**
- you are currently enrolled in Medicaid or have recently been denied Medicaid and Choices for Care coverage.**

2. If all of #1 applies to you, then fill out this application and send it to: Attendant Services Program, Department of Disabilities, Aging and Independent Living, 103 South Main St., Weeks Bldg., Waterbury, VT 05671 or fax to: (802) 828-0599.

3. For questions, call (802) 828-0610 or (802) 871-3069.

B. Applicant Information

Name: _____
First
Middle Initial
Last

TELEPHONE: (____)____-____ DATE OF BIRTH: ____/____/____ GENDER: Male Female

SOCIAL SECURITY NUMBER: ____-____-____ MEDICAID: YES or NO (if no, see Section A. Instructions.)

RESIDENTIAL ADDRESS:

Street
Town
State
Zip

MAILING ADDRESS (if different from residential):

Street
Town
State
Zip

Do you have a legal guardian appointed by a court? YES NO

If yes, name of guardian: _____

C. Self-Screening

Here are some questions to help know whether the Attendant Services Program is a good match for you. If you answer **“YES”** to all of the questions, then the Attendant Services Program *may be a good choice for you*. If you find yourself answering **“NO”** to any questions, then the Attendant Services Program *might not work well for you*.

1. Do I need physical help with at least two of my Activities of Daily Living (ADLs) such as bathing, dressing, grooming, toileting, eating, and bed mobility? (See complete list of ADLs in Section D. Description of Needs.) YES NO
2. Do I communicate easily with others, either by talking, writing, through a translator or an assistive device? YES NO
3. Can I describe to someone else what it is that I need so they can provide attendant care to me? YES NO
4. Can I now, or am I willing to learn how to recruit, hire, train, schedule and supervise care attendants? YES NO (For suggestions, contact the Vermont Center for Independent Living at 800-639-1522.)
5. Can I carry out my employer responsibilities, like hiring and completing time sheets, without the help of another person? YES NO

D. Description of Needs

1. Do you have a permanent and severe physical disability that affects your ability to perform Activities of Daily Living (ADLs) as listed below in question #2? YES NO

If YES, please describe your permanent and severe physical disability:

2. Do you need physical assistance with any of these Activities of Daily Living? (*Check all that apply*)

- Dressing and Undressing (ex: lower and/or upper body)
- Toileting (ex: cleansing self, managing incontinence)
- Bed Mobility (ex: moving to and from a lying position, turning side to side, positioning while in bed)
- Moving around in your home (ex: moving from one room to another)
- Bathing and Showering (ex: shower, full tub or sponge bath)
- Grooming (ex: combing hair, brushing teeth, shaving)
- Transferring (ex: getting in and out of a chair or bed)
- Range of Motion Exercises (ex: reaching above head, twisting side to side)
- Positioning (ex: getting propped up into sitting or lying position)
- Eating (ex: using utensils, including adapted utensils)

3. Who helps you with these activities? _____

E. Applicant Statement & Signatures

- I understand that more information may be required to determine my initial and ongoing eligibility for services.
- I understand that by signing this application, I give the Department permission to obtain and share any personal, health, and financial information used solely to determine my eligibility for services.
- I understand that all information will be respected as confidential and will be used solely to facilitate receiving services. I can revoke my consent at any time by contacting the Department.
- I understand, that if found eligible, I agree to comply with the regulations governing the Attendant Services Program, including submitting payroll information required by the State's Attendant Services Program. (A copy of the regulations are available on the internet at <http://www.ddas.vermont.gov/ddas-programs/attendant-services-program/asp-regulations-2-15-2013> or by calling (802) 828-0610. Information about payroll services can be found at <http://fa.arissolutions.org/> or by calling (800) 798-1658.
- I understand that I will be notified of my eligibility or ineligibility in writing, to include appeal rights.
- I have read the information in this application and certify that the information is true and accurate to the best of my knowledge.

Applicant's Signature: _____ **Date:** _____

Witness to mark if unable to sign name: _____

Guardian's Signature if applicable: _____ **Telephone:** _____

Person/Agency helping to apply: _____ **Telephone:** _____