|  |  |  |
| --- | --- | --- |
| Date Application Completed | **Applicants Date of Birth \* Must be 60 or older** | Gender |
|  | DOB: | \_\_\_ Male \_\_ Female |
| Ethnicity  **1** - Hispanic or Latino  **2** - Not Hispanic or Latino | Race  **1**- American Indian/Alaskan Native **2** Asian - **3** Black/African American **4** Native Hawaiian/Other Pacific Islander **5** White  **6** Other | |

How did you hear about the program**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1: Current Living or Residential Setting**

|  |
| --- |
| Check the setting where the applicant is currently living |
| \_\_\_Own home \_\_\_ At the home of a family member or friend |
| \_\_\_Rent (Apartment or Home) **\*The rental property owner must agree to modifications.\* See Instructions** |
| Lives alone \_\_\_ Yes \_\_\_ No If no, who does the applicant live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Street Address |  |
| Mailing Address (if applicable) |  |
| City, State and Zip Code |  |
| County |  |
| Telephone Number |  |
| Email Address |  |
| Directions and description |  |

|  |
| --- |
| Please explain your situation/modification need and **how the modifications and/or items requested will help you remain in your home/community.** (Medical conditions, medical need for the item, etc.) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 2: Activities of Daily Living and Instrumental Activities of Daily Living**

|  |  |  |
| --- | --- | --- |
| Check the following activities you need assistance with. | | |
| \_\_ Bathing  \_\_ Dressing  \_\_ Grooming (combing hair, nail care)  \_\_ Walking  \_\_ Transferring (sitting to standing; lying down to  standing; shower to commode)  \_\_ Wheeling  \_\_ Toileting  \_\_ Feeding Self  \_\_ Preparing meals | \_\_ Climbing Stairs  \_\_ Sleeping  \_\_ Breathing  \_\_ Seeing  \_\_ Hearing | Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 3: Services Information**

|  |  |
| --- | --- |
| Are you a Medicaid member? | \_\_\_ Yes \_\_\_ No |
| Do you receive in-home supports from Medicaid Waiver Services? | \_\_\_ Yes \_\_\_ No |
| Are you on the waiting list for Medicaid Waiver Services? | \_\_\_ Yes \_\_\_ No |
| Are you a Medicare member? | \_\_\_ Yes \_\_\_ No |
| Do you participate in the Take Me Home WV Money Follows the Person Program? | \_\_\_ Yes \_\_\_ No |
| Do you participate in the Olmstead Transition and Diversion Program? | \_\_\_ Yes \_\_\_ No |
| Are you on a Centers for Independent Living Community Living Services and Supports waiting list? If yes, what service/support are you waiting for?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Yes \_\_\_ No |
| Do you receive services from a Senior Center? | \_\_\_ Yes \_\_\_ No |

**Section 4: Financial Information**

|  |  |
| --- | --- |
| Applicant’s total monthly income. **(Before any deductions)** | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any financial resources (Checking, Savings, CD’s, stocks, etc.) | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Additional income from other household members. | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Check all that apply toward Applicant’s monthly income.  \_\_\_ Wages \_\_\_ Supplemental Security Disability Income  \_\_\_ Social Security Benefits Income \_\_\_ State Assistance Programs  \_\_\_ Veterans benefits \_\_\_ Worker’s Compensation  \_\_\_ Rental Property income \_\_\_ Pension or Retirement income  \_\_\_ Investment or Trust fund income \_\_\_ Unemployment Compensation  \_\_\_ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Section 5: Other Information**

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| --- |
| Please provide any other information you would like to be considered in your request (medical expenses, debts, dependents, documentation of need from a physician, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 6: Funding Request Proposal**

**Requested Item(s) and Cost**

|  |  |  |
| --- | --- | --- |
| **Category** | **Item(s) Requested** | **Estimated Cost**  **\*\*See Instruction Sheet** |
| Durable medical equipment, assistive devices, or technology |  |  |
| Home modifications or accessibility adaptations |  |  |
| Have you applied for funding through the West Virginia Bureau of Senior Services Home Modification and Accessibility Program in the past? \_\_\_ Yes \_\_\_ No If yes, date of prior application: \_\_\_\_\_\_\_\_\_ | | |
| Have you asked any other programs for help with paying for the requested item/service?  \_\_\_ Yes \_\_\_ No If yes, please list those programs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If your request exceeds the $3000 allowable under this program, please explain where you will get the rest of the money to pay for the item/services requested. (If money is coming from another organization, documentation verifying this must be attached.)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Section 7: Certification and Authorization**

|  |
| --- |
| My signature indicates the information provided in this application is accurate and complete to the best of my ability. My signature authorizes the release of information enclosed in the application to determine eligibility for the program. |
| Applications must be signed by the applicant or the legal representative (please provide legal representative authorizing documentation). |
| **I give my permission to talk to:**  Family member name and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Legal Representative name and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (A copy of 1 (one) authorizing document must be provided.)  Case Manager name and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other individual name and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant**

**Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Representative (if applicable)**

**Return Application to:**

WV Aging & Disability Resource Center

1400 Ohio Avenue, Suite B

Dunbar, WV 25064

Fax to: (304) 766-4137 or email to [ADRC@wvstateu.edu](mailto:ADRC@wvstateu.edu)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Reviewer Initials  1. \_\_\_Yes or \_\_\_ No \_\_\_\_\_\_  2. \_\_\_Yes or \_\_\_ No \_\_\_\_\_\_  3. \_\_\_Yes or \_\_\_ No \_\_\_\_\_\_  **Notes/Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |