OPTIONS for Independence Independent Living Program Application

OPTIONS for Independence is a consumer controlled, community based, cross disability, nonresidential, private nonprofit agency for individuals with all types of significant disabilities. OPTIONS provides an array of independent living services to help people with significant disabilities lead independent lives, make decisions about their lives and fully participate in the community setting of their choosing.

Today's Date: _____

Have you previously received services from a Center for Independent Living:

[]No	[]Y	es – where a	nd when				_
1.	Social	Security Nun	1ber		Date of Birth		
2.	Phone	Number				MM/DD	YEAR
3.	Name						
4.	Addres	ss Street Addr	ess			Age	
		Mailing Add	ress (if differe	nt)			
		City		State	Zip	Count	у
5.	Gende	r Preference	:				
6.	 Race and Ethnicity (mark any that apply) [] American Indian/Alaska Native [] Asian [] Black or African American [] Native Hawaiian or other Pacific Islander [] White [] Hispanic/Latino of any Race 						
7.		ll Status ver Married	[] Married	[] Divorced [] Widowed	[] Separated	

INFORMATION CONTAINED IN THIS APPLICATION WILL BE KEPT CONFIDENTIAL

	Consumer Number: Contact Person:								
	Number of Dependents								
8.	How did you hear about OPTIONS?								
9.	What is your disability (ies)								
	How does your disability limit your independence								
10.	Do you currently receive a cash benefit from Social Security Disability Income (SSDI) [] Currently allowed benefits – Amount received \$								
	[] Not an applicant								
	[] Application Pending								
	[] Denied benefits – reason								
	[] Benefits discontinued – Date								
11.	Do you currently receive a cash benefit from Supplemental Security Income (SSI) [] Currently allowed benefits – Amount received \$								
	[] Not an applicant								
	[] Application Pending								
	[] Denied benefits – reason								
	[] Benefits discontinued – Date								
12.	Do you currently receive retirement income from the Social Security Administration (SSA)								
	Amount received \$								
	[] Not an applicant								
	[] Application Pending								
	[] Denied benefits – reason								
	[] Benefits discontinued – Date								
13.	Do you receive Medicaid								
	[] No [] Yes – Amount \$								
	General Assistance								
	[] No [] Yes – Amount \$								
	Temporary Assistance to Needy Families (TANF)								
	[] No [] Yes – Amount \$								
	Other Public Support								
	[] No [] Yes – Amount \$								

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Consumer Number: Contact Person:						
Are you currently or have you ever received Vocational Rehabilitation Services [] No [] Yes – when Did you receive the help you needed						
Have you been in the Military [] No [] Yes [] Eligible for Veterans Benefits If yes, do you know how to access Veteran Services [] No [] Yes						
What is your level of education						
Are you currently attending school: [] No [] Yes – School						
Have you ever had or been eligible for an Individual Education Plan (IEP): [] No [] Y						
Vhat are your living arrangement						
Are you currently working [] No [] Yes – hours work per week						
Do you have services available to you from any of the following: Medicare [] Medicaid [] Private Insurance []						
Easter Seals [] Shriners [] Muscular Dystrophy []						
M. S. Society [] Religious Org. [] Vocational Rehabilitation []						
Family/Friends [] Veterans Admin. [] United Cerebral Palsy []						
Fraternal Org. [] Other [] specify						
What is the primary source of your income/support at this time						
Do you feel safe in your home: [] No [] Yes						
What are your current needs and how can OPTIONS help:						

The information contained in this application is true and correct to the best of my knowledge. I understand OPTIONS for Independence has an obligation to keep my personal information, identifying information, and my consumer service records confidential. Permission is granted

Contact Person:_____

for OPTIONS for Independence (IL Coordinator) to make inquiries that might be necessary to verify the statements made in this application. In applying for independent living program services, I understand there is a need to collect personal information.

I understand consumer service record information is necessary to determine eligibility and, therefore, mandatory. Failure to provide requested information may result in a determination that I am not eligible for independent living program services.

I understand I have the opportunity for a timely review of any dissatisfaction with a determination made by my Independent Living Coordinator concerning the furnishing or denial of Independent Living services by contacting:

Cheryl Atwood, Executive Director at 435-753-5353.

I understand a **Client Assistance Program** representative is available to act as my advisor or advocate, and that I may call toll free (800) 662-9080 or in Salt Lake City (801) 363-1347 to reach the Disability Law Center/Client Assistance Program (CAP), 205 North 400 West, SLC, UT 84103.

I understand services in this program are provided without regard to gender, sex, race, age, color or national origins according to Title VI of the Civil Rights Act and Section 504 of the Rehab Act of 1973, as amended. OPTIONS for Independence also assures no group of individuals will be excluded or found ineligible on the basis of type of disability.

Consumer/Guardian/Representative Signature

Date Signed

Would you like to register to vote? [] No [] Yes This information will not affect your eligibility.

If you have questions, regarding this application contact OPTIONS at 435-753-5353.

Please return this completed form to:

OPTIONS for Independence 106 East 1120 North Logan, UT 84341

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