Application for Services

Section I

I am applying for assistance from LIFE (Living Independence For Everyone). By signing this form, I verify that as is required to be assisted by LIFE, I have a significant disability (defined as a severe mental or physical impairment) that:

1.A Substantially limits my ability to function independently in the community or;

1.B Substantially limits my ability to obtain, maintain, or advance in employment and;

2. The delivery of independent living services will improve either:

A. My ability to function, to continue functioning or to move toward functioning independently in the community or;

B. My ability to continue employment

I understand that information about my disability and its effects may be shared, for my benefit with other programs (example: MS Department of Rehabilitation Services,) and, by signing this form, I give permission for that information to be released. Initial here:_____

I understand that if I am not satisfied with the assistance I am provided, I may appeal to the State Board of LIFE by writing to: State LIFE Board, 1304 Vine St., Jackson, MS 39202; or call 1-800-748-9398 or 601-969-4009.

I understand that there is a statewide Client Assistance Program and I have a right to use their services. CAP staff can give advice and provide clarification about the services provided by LIFE, the Department of Rehabilitation and other agencies. If I am dissatisfied by the services provided by LIFE, the CAP can work with me and LIFE staff to help resolve the problem. I understand that I may contact CAP by phoning 1-800-962-2400 or 601-362-2583.

I understand that LIFE does not discriminate in hiring or in providing services on the basis of disability, race, sex, creed, religion, or national origin.

Section II: We need some personal data from you to assist you in planning the services you need.

Name _____ 2. Date of Application _____

Address _____ City_____ County_____

Zip_____ Telephone _____ Date of Birth_____

Sex ____ Race _____ Primary Disability_____ Secondary _____

Date Disability Began _____ Doctor's Name _____

SS# _____ Marital Status_____ Who referred you _____

How Do You Live (circle one): Independently Parents/Guardian Institution Group Home Other

Resources Available (circle all that apply): SSDI $_____ SSI $_____ Retirement $_____
State Job VA Medicaid Waiver Other _____

Medical Benefits Available (circle): Medicare Medicaid Children's Medical Program VA
Private Health Insurance? List Co_____ Other?_____

Are you registered to vote? Yes No Do you want assistance in registering? Yes No

LIFE would like to add you to our emailing list to inform you of special events. Please provide your email address, if interested:_____

Applicant's Signature (or Applicant and Parent/Guardian) Date