



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



INDIVIDUALIZED INDEPENDENT LIVING PLAN

Goals and Services

| Goals | Services | Beginning Date | Projected Ending Date | Goal End Date |
|-----------------------|----------|----------------|-----------------------|---------------|
| Self-Care | | | | |
| Communication | | | | |
| Mobility | | | | |
| Residential | | | | |
| Educational | | | | |
| Vocational | | | | |
| Community Integration | | | | |
| Transportation | | | | |
| | | | | |

Core Services Available

Peer Counseling and Support
Skills Training/Life Skills Training

Information and Referral Services
Individual and Systems Advocacy

Youth/Transition Services
Adult/Transition Services

Description of services to be provided: _____

1. I, the Independent Living Specialist, through the agreed upon services(s) listed above will assist the consumer to achieve their goals.

I, the consumer, through the agreed upon service(s) listed above will participate in the service(s) so that I can achieve my goal(s).

I, the consumer, will communicate with the IL Specialist regarding the referrals made on my behalf for services listed above.

Consumer Signature (or Parent/Guardian)

IL Specialist Signature

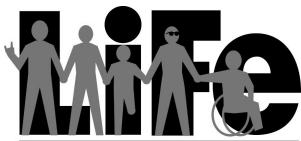
Date

2. I, the Consumer, have chosen to waive the assistance of an Independent Living Plan.

Consumer Signature (or Parent/Guardian)

IL Specialist Signature

Date



Living Independence For Everyone of Mississippi

Dedicated to the Empowerment
of Individuals with Disabilities

ELIGIBILITY STATEMENT

The eligibility of most consumers will be established by their signing LIFE's Application for Services form. That document includes a statement verifying the presence of a significant physical or mental disability. However, in cases where the services provided by LIFE will include assistance beyond the core independent living services of peer support, skills training, information and referral and advocacy, eligibility for those additional services will have to be established. This Eligibility Statement will need to be permanently located in the Consumer Service Record.

LIFE Office Location: _____

Specialists Name: _____

Consumer's Name: _____

Date: _____

Services Planned: _____

ADDITIONAL ELIGIBILITY STATEMENT:

In the following statement, the Specialist must verify that the consumer has a “significant disability” as defined by a severe physical or mental impairment that:

- 1. Substantially limits his/her ability to function independently in the family or community; or**
- 2. Substantially limits his/her ability to obtain, maintain, or advance in employment; and**
- 3. The delivery of independent living services will improve either**
 - a. His/her ability to function, to continue functioning or to move toward functioning independently in the family or community; or**
 - b. His/her ability to continue employment.**

Such verification will need to specify below where medical record, or other substantiating documentation exists that establishes the significance of the disabling condition. Verification can include that the consumer is receiving SSI or SSDI benefits or payments or has been determined eligible for other service programs for people with significant disabilities such as the Department of Rehabilitation Services).

Dr.’s Name & Phone #

Medicaid #

Medicare #

IL Specialists Signature

Date



FINANCIAL STATEMENT

Criteria for Financial Assistance for LIFE is as follows:

1. There must be a current Application for Services in the consumer's case record
2. The individual requesting assistance must have a significant disability according to the definition in the Rehabilitation Act of 1973, as amended, and a current Eligibility Statement must be on file in the consumer's record
3. The requested service or assistance must be deemed appropriate for the individual by a qualified professional
4. The service or assistance must allow the individual to do at least one of the following:
 - a. Increase control over his/her environment
 - b. Significantly increase functional capacity to participate in activities at home, school, work, or in the community
 - c. Increase interactions in their communities
5. Funding for the requested service or assistance must not be available from an alternate source
6. Individuals receiving assistance should participate financially in the procurement of their services to what ever degree possible. The scale for financial assistance is as follows:

| Adjusted Monthly Income* | Level of Service | LIFE Funding Available |
|--------------------------|------------------|------------------------|
| \$2,000 or above | \$0 – 250 | \$0 |
| | 251 – 500 | 0 |
| | 501 - 750 | Up to 25% |
| | 751 – 1,000 | Up to 50% |
| | 1,001 – 1,500 | Up to 75% |
| | 2,501 and up | Up to 100% |
| \$1,700 - \$1,999 | \$0 - \$250 | \$0 |
| | 251 – 500 | Up to 25% |
| | 501 – 750 | Up to 50% |
| | 751 – 1,000 | Up to 75% |
| | 1,001 and up | Up to 100% |
| \$1,250 - \$1,699 | \$0 - \$250 | Up to 25% |
| | 251 – 500 | Up to 50% |
| | 501 – 750 | Up to 75% |
| | 751 and up | Up to 100% |
| \$850 - \$1,249 | \$0 - \$250 | Up to 50% |
| | 251 – 500 | Up to 75% |
| | 501 and up | Up to 100% |
| \$500 - \$849 | \$0 - \$250 | Up to 75% |
| | 251 – 500 | Up to 100% |
| Below \$499 | \$0 and up | Up to 100% |

* To calculate the adjusted income, the household's monthly gross income is divided by the number of dependents living in the home



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of Individuals with Disabilities*

STATE OFFICE
1304 Vine Street
Jackson, MS 39202
601-969-4009 or 1-800-748-9398

STATEMENT OF CONSUMER CHOICE

I, _____, acknowledge that Living Independence for Everyone (LIFE) has provided me with information regarding my choice of vendors for the durable medical equipment, supplies, repairs or vehicle modifications I am receiving through this office. A list of available vendors has been presented to me and my choice of vendor is

_____.

I understand that should this vendor be unavailable or refuse to provide a comparable dealer discount, that I will have the option of another choice, unless the vendor is a sole provider of the needed service.

Consumer Signature (or Legal Guardian)

Date