VERMONT

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

A. Instructions

If you are not currently enrolled or have not recently been denied Medicaid or Choices for Care you **must** apply for Medicaid or Choices for Care eligibility determination prior to applying for the Attendant Services Program. To obtain a Medicaid application call 1-800-479-6151 or visit:
http://www.greenmountaincare.org/apply-online-health-insurance

Fill out this application if **ALL** of these apply to you:

- You are Vermont resident 18 years or older, AND
- You have a permanent and severe physical disability that affects your ability to perform at least two Activities of Daily Living (ADL's) 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 or Choices for Care coverage

Please send applications to:

Attendant Services Program
Department of Disabilities, Aging and Independent Living
HC 2 South 280 State Drive
Waterbury, VT 05671-2070
or fax to: (802) 241-9064

For questions please call: (802) 241-0298

B. Applicant Information

Name: _____
First Middle Initial Last

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Gender: ☐ Male ☐ Female

Medicaid: ☐ Yes ☐ No (If no, please see section A: Instructions on how to apply)

Physical Address:

Street: _____ City: _____ State: _____ Zip : _____

Mailing Address (if different than above):

Street: _____ City: _____ State: _____ Zip : _____

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

If yes, name of guardian: _____

C. Self-Screening

Please answer the following questions to help determine if the Attendant Services Program is right for your needs.
If you answer "YES" to **ALL** of the questions, then the Attendant Services Program may work well for you.
If you find yourself answering "NO" to any questions, then the Attendant Services Program may not work well for your needs.

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 Section D for complete list)
   ☐ 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
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)
   ☐ 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 adaptive 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.
- I understand a amnw md rfc pcesj_rgmlq _pc _t_gj_`jc `w _r8 frrn8--_qb,tcpkmlr,emt-pcqmspacq-qr_rsrcq+pcesj_rgmlq mp `w a_jjgle &6.0' 02/+.076
- Dmp n_wpmjj oscqrgmlq _lb gldmpk_rgml njc_qc tgqgr8 frrn8--uuu,_pgqqmjsrgmlq,mpe-mp a_jj /&6..' 576+/436
- G slbcpqr_lb rf_rG ugjj `c lmrgdgcb md kw cjgeg`gjgrw mp glcjgeg`gjgrw gl upgrgle* rm glajsbc _nnc_j pgefrq,
- G f_tc pc_b rfc gldmpk_rgml gl rfgq _nnjga_rgml _lb acprgdw rf_r rfc gldmpk_rgml gq rpsc _lb _aasp_rc rm rfc `cqr md kw ilmujcbec,

Applicant Signature: _____ Date: _____

Witness if applicant unable to sign: _____ Date: _____

Guardian or Agency helping to apply: _____ Telephone: _____

Guardian Signature (If applicable): _____ Date: _____