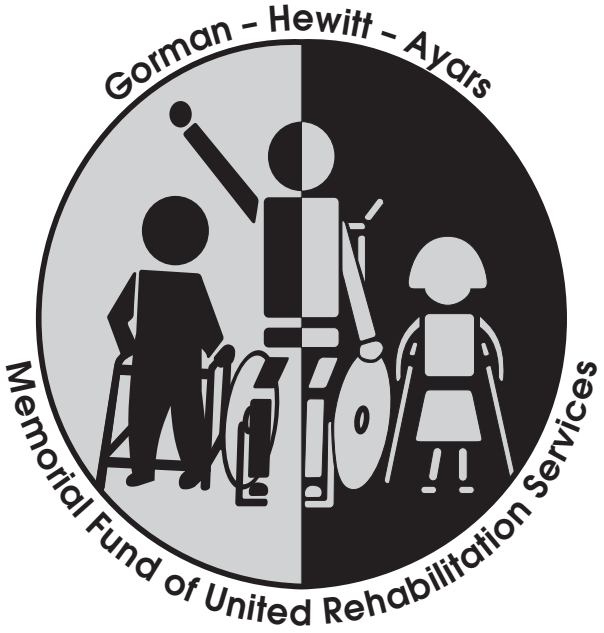
Application for Eligibility Determination

Date _____



A better life for those with physical disabilities.

Personal Information of Those Who Will Receive Services

Name of individual with disability _____

Address _____ *City* _____ *Zip* _____ *County* _____

Home telephone ( ) _____ *Alternate telephone ( )* _____ *Male/Female* _____

Date of birth _____ *Social security number* _____ – _____ – _____ *Parent or guardian* _____

Nature of disability _____

Medical Information

Please check all that apply to the person's disability. If you need additional space, use the lines provided below.

- ❑ *Amputee*
- ❑ *Ankylosis (joint disease)*
- ❑ *Arthritis*
- ❑ *Cerebral Palsy*
- ❑ *Chronic Osteomyelitis (bone disease)*
- ❑ *Epilepsy*
- ❑ *Multiple Sclerosis*
- ❑ *Muscular Dystrophy*
- ❑ *Poliomyelitis*
- ❑ *Scoliosis*
- ❑ *Seizures*
- ❑ *Spina-bifidia*

Additional space _____

_____

List any special equipment needs (crutches, braces, wheelchair, communication aid, helmet, etc...) _____

_____

Equipment needed at this time _____

Family doctor name _____

Address _____ *City* _____ *Zip* _____ *Telephone ( )* _____

Insurance Information

Insurance type (Medicaid/Medicare, other) _____

Insurance company name _____

Address _____ *City* _____ *Zip* _____ *Telephone ( )* _____

Identification no. (Medicaid/Medicare, other) _____ *Percent of coverage (insurance)* _____

1) *Do you have a current application on file with your local County Board of Mental Retardation and Development Disabilities?* ❑ *Yes* ❑ *No*

   If yes, please list contact person's name _____

2) *Have you received services or equipment from your local County Board of Mental Retardation and Development Disabilities in the past?* ❑ *Yes* ❑ *No*

   If yes, please indicate the month/day/year received _____

3) *Do you currently have a doctors prescription for requested services or equipment?* ❑ *Yes* ❑ *No*

   If yes, please explain _____

4) *Are you currently enrolled in school, habilitation, workshop, or a training program?* ❑ *Yes* ❑ *No*

   If yes, please give name _____ *Address* _____

5) *Has individual ever been evaluated?* ❑ *Yes* ❑ *No*

   If yes, who did the last evaluation _____ *Date* _____

Insurance Information (continued)

Please list all the individuals who live with the disabled person.

Name	Relationship	Age	Male/Female

Income Certification

I hereby certify that my taxable income was $ _____ for _____ (enter prior year)

Signature (applicant, parent or guardian) _____ Date _____

OR

I did not have any taxable income for last year, which was _____ (enter prior year)

My only source of income is _____ (SSA/SSI, ADC, etc..) Amount received per month $ _____

Signature (applicant, parent or guardian) _____ Date _____

I certify that the information on this application is correct. I understand that the Gorman – Hewitt – Ayars Memorial Fund has the right to verify the information given by me on the application and may require documentation to verify disability or income eligibility. A home visit may be made by a designee of the Gorman – Hewitt – Ayars Memorial Fund to assure that requested services and equipment are appropriate and meet quality standards.

I also agree that the Gorman – Hewitt – Ayars Memorial Fund has permission to share information pertaining to the disabled individual with vendors and/or agencies when needed, to provide for services and equipment.

Signature (applicant, parent or guardian) _____ Date _____

Office Use Only

Date received _____ Co-payment amount _____

Date approved _____ Verification letter sent _____

Notes: _____

_____

_____

Fact Sheet (For Office Use Only)

For more information, please contact:

Gorman – Hewitt – Ayars
Memorial Fund of UCP
4710 Old Troy Pike
Dayton, Ohio 45424

www.unitedrehabservices.org

937-233-1230

Printed in U.S.A.
GHA-100-0999