IL-1
01/15

ACTIVE RE-ENTRY
INDEPENDENT LIVING PROGRAM APPLICATION

Date:_____

Name:_____ **Male**_____ **Female**_____
(Please Print)

Guardian's Name:_____

Address:_____ **P.O Box #**_____

City:_____ **State**:_____ **County**:_____ **Zip**:_____

Phone: (_____)_____ **Alternate Phone**: (_____)_____

Emergency Contact:_____ **Phone**: (_____)_____

Social Security Number:_____ **Date of Birth**:_____
(for State funding only)

Race: (May select more than one category)
White:___ African American:___ Hispanic of Latino:___ Asian/Pacific Islander:___ American Indian:___

Marital Status: Never Married:___ Married:___ Divorced:___ Widowed:___ Separated:___

Living Situation: (Check only one) Nursing Home:___ Group Home:___ Rent to Own:___ Assisted Living:___
Parent/Guardian Home:___ Homeless:___ Renting House/Apartment:___ Own Home:___ Friends/Family:___

Are you presently employed? Yes___ No___ Are you presently retired? Yes___ No___

What is your educational level?_____ Have You ever had an IEP? Yes___ No___

Are you presently attending school? Yes___ No___ If YES, Name of school_____

Have you been in the Military? Yes___ No___ Are you eligible for veteran's benefits? Yes___ No___

Disability Information
Primary Disability:_____ Onset Date_____

Cause:_____

Secondary Disability(s)_____

_____ Cause:_____

Are you currently receiving a cash benefit from **SSDI**?

Yes currently allowed benefits:____ NO not an applicant:____ Denied benefits:____

Are you currently receiving a cash benefit from **SSI**?

Yes currently allowed benefits:____ NO not an applicant:____ Denied benefits:____

Are you receiving services or have you received services from: (Check all that apply)

Medicare:____ Medicaid:____ Other Medical Insurance:____ Waiver Programs____

Muscular Dystrophy Society:____ HEAT:____ General Assistance:____ Shriners:_____

Unemployment Benefits:____ Vocational Rehabilitation:____ Food Stamps:____ M.S. Society:____

Weatherization:____ Other (specify):_____

Have you previously received services through a Center for Independent Living? Yes___ No___

If YES where:_____

Please write a statement of your needs and how you feel the Independent Living Programs can help.

_____

_____

_____

_____

Who referred you to this program?_____

Are you a registered Voter: Yes___ No___ If NO would you like to register? Yes___ No___

Do you wish to receive our quarterly newsletter? Yes___ No___

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Active Re-Entry Independent Living Center
Social Recreation/Media Release

I,_____, do hereby release Active Re-Entry Independent Living Center and its Board of Directors and employees from all liability, claims, and/or demands for property damage and personal injury that may arise from an accident or injury while attending program activities or being transported to and from these activities. I also hereby authorize Active Re-Entry Independent Living Center to take and utilize photographs, videos or other audio-visual materials for its own use. These materials will be used for public awareness, public relations and fundraising activities. I also understand that I will not be compensated monetarily or otherwise for the use by Active Re-Entry.

Active Re-Entry Independent Living Center
Hold Harmless Release

I,_____, for and in consideration of permission granted by be to participate in Peer Support group meetings and Community Integration activities do hereby release and agree to hold harmless Active Re-Entry Inc., Independent Living Center, their successors and assigns, for all claims, demands, actions and causes of the action at law or equity, arising by reason or in manner growing out of participation in Active Re-Entry activities. Further, I understand that Active Re-Entry, Independent Living Center does not provide accidental medical insurance for participants while engaged in sponsored activities. Securing appropriate medical insurance is the responsibility of the participant or the participant's family.

Transportation Statement

I, _____ understand that all reasonable efforts will be made to provide safe transportation. I, the undersigned, for and in consideration of permission granted by me do hereby release and agree to hold harmless Active Re-Entry and other agencies involved for all claims, demands, actions and causes of the action at law or equity, arising by reason or in a manner growing out of participation with Active Re-Entry. Further, I understand that Active Re-Entry does not provide accidental medical insurance for the riders. Van/Bus insurance is in accordance with existing Utah State Law.

_____ _____

Consumer or Guardian Signature Date

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01/15

Rights and Signature

The information contained in this form is true and correct to the best of my knowledge. Permission is granted to the Independent Living Program to make whatever inquiries might be necessary to verify these statements. In applying for independent living program services, I understand there is a need to collect personal information.

I understand that consumer service record information is necessary to determine eligibility and, therefore, mandatory. Failure to provide requested information may result in a determination of not being eligible for Independent Living Services.

I understand that consumer service record information concerning me will be kept confidential.

I understand that I have the opportunity for a timely review of any dissatisfaction with a determination made by my Independent Living Coordinator concerning the furnishing of denial of Independent Living Services by contacting: Nancy Bentley, Executive Director, 435-637-4950

I understand that a Client Assistance Program Representative is available to act as my advisor and advocate, and that I may call toll free 1-800-662-9080 or Salt Lake 801-363-1347 to reach the Disability Law Center / Client Assistance Program (CAP), 205 North 400 West Salt Lake City, UT 84103

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

_____ _____

Consumer or Guardian Signature Date

_____ _____

ARECIL Service Coordinator Date

ACTIVE RE-ENTRY
Independent Living Programs
www.arecil.org

Price Office
10 South Fairgrounds Rd
Price, UT 84501
435-637-4950

Moab Satellite Office
P.O. Box 122
Moab, UT 84532
435-259-0245

Vernal Satellite Office
P.O. Box 580
Vernal, UT 84078
435-789-4021
435-789-4020

IL-1a
06/07

INDEPENDENT LIVING PROGRAM
CONFIDENTIAL REPORT OF FINANCIAL CIRCUMSTANCES

In order for you and your IL Coordinator to determine financial need for the services outlined in your Independent Living Plan, the following financial information is required. (Note: Minors living with parent(s) must include the parent(└F¿ income. Married applicants must include the income of their spouse.) Tax forms, check stubs, retirement documents, and other forms of verification may be required.

_____/_____
Full Name Age

[ ] I choose not to complete the financial disclosure form. In doing so, I understand that I will **not** be eligible to receive paid Independent Living assistive technology services.

Family Size _____ Include all household members included as dependents on federal tax forms. (If you don't file federal taxes, include all household members who could be included as dependents if you did file.)

Number of dependents 18 years or older_____
Number of minor dependents _____

1. ***Monthly*** Supplemental Security Income (SSI) $_____

2. ***Monthly*** Gross Earned Income
   - Your own $_____
   - Parent(s) (if a minor) $_____
   - Income of spouse $_____

   Total ***Monthly*** Earned Income $_____

3. Allowable Deductions from ***Monthly*** Earned Income
   - State and Federal Tax $_____
   - FICA $_____
   - Retirement you pay $_____

   Adjusted Gross ***Monthly*** Income $_____

4. Additional ***Monthly*** Income
   - Alimony and Child Support $_____
   - Veterans Pension $_____
   - Interest or Dividend Income $_____
   - Social Security Retirement $_____
   - Workers Compensation $_____
   - Social Security Disability Insurance (SSDI) $_____
   - Other Disability compensation $_____

   Total Additional ***Monthly*** Income $_____

   Add Adjusted Gross ***Monthly*** Inc. $_____

5. Total ***Monthly*** Non-exempt Income $_____

6. Liquid Assets (include all liquid assets unless in a qualified retirement account)
   - Savings Account $_____
   - Other Liquid Assets $_____

   Total Liquid Assets $_____

Do you anticipate any significant changes in your financial circumstances within the next year? Y / N
If yes please list the source _____ Please list the *monthly* amount $_____

Allowable *Monthly* Expenses You Pay

Monthly court ordered support payments i.e. alimony or child support for children **not** counted as family members on the front of this form (fines, restitution, and other non-support payments are not allowed). $_____

Monthly medical and dental expenses which are **not** reimbursed $_____

Monthly health insurance premiums (your portion) $_____

Other ***monthly*** disability related expenses which are **not** reimbursed

Personal assistance services $_____

Disability related transportation expenses $_____

Repairs to prosthetic appliances, mobility aids, and adaptive equipment $_____

Monthly cost of therapy $_____

Monthly cost of any disability related service for spouse or dependent $_____

Other ***monthly*** disability related expenses not included above

_____ $_____

_____ $_____

7. Total *Monthly* Allowable Expenses $_____

I certify that the information contained in this form is true and correct to the best of my knowledge. Inaccurate or falsified information may be cause for denial of Independent Living paid services conditioned on financial need. ***I will immediately notify the Independent Center of any change(s) to my financial circumstances.***

_____ _____

Signature of Consumer/Representative **Date**