ADRC of Hilltop
Client Services/Financial Assistance Application

The information collected in this application is required by the Older Americans Act / NAPIS Project in order for our program to receive continued funding. Please fill out this form completely (front & back). Thank you for your cooperation.

Client Name: _____
(last name) (first name) (middle initial) (nickname)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing Address (if different than above)**:** _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **Date of Birth:** _____ **Age:** _____ **Social Security #:** _____

Race/Ethnicity:
- ☐ African American
- ☐ Hispanic/Latino
- ☐ American Indian/Alaskan Native
- ☐ White
- ☐ Asian/Pacific Islander

Marital Status:
- ☐ Married
- ☐ Single
- ☐Divorced
- ☐ Widowed
- ☐ Other

Employment:
- ☐ Fulltime
- ☐ Part-time
- ☐ N/A/Retired

What is your primary language?: _____

Are you a veteran?:
- ☐ Yes
- ☐ No

Spouse of a veteran?:
- ☐ Yes
- ☐ No

Emergency Contact Name: _____ **Phone #:** _____ **Relationship:** _____

Name of your primary physician: _____ **Phone #:** _____

What is your living arrangement?:
- ☐ Live Alone
- ☐ Live w/Spouse
- ☐ Live w/Extended Family
- ☐ Live w/Non-relatives

Where do you live?:
- ☐ Own Home
- ☐ Rent home/apartment
- ☐ Family member's residence
- ☐ Long-term Care Facility
- ☐ Subsidized Housing/Senior Community
- ☐ Group Home
- ☐ Homeless
- ☐ Other (Please Describe): _____

Do you have a disability or illness that affects your daily life?

Check all that apply:
☐Physical Disability ☐Developmental Disability ☐Mental Illness ☐Dementia
☐Traumatic Brain Injury ☐Unspecified Disability ☐Unknown Disability ☐Multiple Disabilities ☐No Disabilities

What type of service or materials are being requested?**:** _____

Please explain in detail why this assistance is needed.

_____

_____

_____

_____

_____

_____

_____

Monthly Household Income:

Source of Income:	Monthly Amount (gross)	Source of Income:	Monthly Amount (gross)
Social Security Retirement (SA)		Veterans Benefits/Pension	
Supplemental Security Income (SSI)		Retirement/ Pension	
Social Security Disability Income (SSDI)		Employment (fulltime or part time)	
Old Age Pension (OAP)		Unemployment Benefits	
Temporary Aid to Needy Families		Food Assistance (Food Stamps)	
(TANF) Aid to the Needy Disabled (AND)		Other Source of Income	

Do you receive Medicaid? ☐ Yes ☐ No

Do you receive Medicare? ☐ Yes ☐ No

Do you use assistive devices? Yes ☐ No ☐

If so, which ones:

Walker ☐ Wheelchair ☐ Crutches ☐

Cane ☐ Electric Scooter ☐ Other ☐

Are you visually impaired (cannot be corrected with glasses)**?** ☐ Yes ☐ No

Monthly Household Expenses:

Rent/Mortgage: _____ Trailer/Lot Rent: _____ Water/Sewer: _____ Gas/Electric: _____

House Phone: _____ Cell Phone: _____ Health Insurance (supplemental not Medicare/Medicaid) _____

Life Insurance: _____ Auto/Car Payments: _____ Auto/Car Insurance: _____

Medical Copays: _____ Pharmacy: _____ Food (not including SNAP Benefits) _____

Other monthly expenses: _____

What are you able to contribute to the cost of service?: _____

Options Counselor or Case Manager Use Only:

I can eat without help.	☐ Yes ☐ No	I can take care of shopping without help.	☐ Yes ☐ No
I can dress myself without help.	☐ Yes ☐ No	I can take my medication without help.	☐ Yes ☐ No
I can bathe myself without help.	☐ Yes ☐ No	I can prepare meals without help.	☐ Yes ☐ No
I can use the toilet without help.	☐ Yes ☐ No	I can do ordinary housework without help.	☐ Yes ☐ No
I can get in & out of bed/chairs without help.	☐ Yes ☐ No	I can use the telephone without help.	☐ Yes ☐ No
I can get around inside my home without help.	☐ Yes ☐ No	I can use transportation without help.	☐ Yes ☐ No

By signing below, I understand and acknowledge the following:

-The information from this application is used to determine eligibility and service through ADRC of Hilltop.

-I understand I am responsible for selecting a provider.

-ADRC of Hilltop is not the employer of record and does not license, certify, conduct criminal background checks or otherwise control providers and is not responsible for care, quality of care or services.

-I authorize ADRC of Hilltop to release protected health information from this application only as it relates to my treatment, payment, provisions of services, and/or care.

Please sign and date the application and return it to ADRC of Hilltop, at 1129 Colorado, Grand Junction, CO 81501 or email us at ADRC@htop.org. If you have any questions about the application please call our office at 970-248-2746, option 1.

_____ _____

(name/Signature) (date)

_____ _____

(name of person assisting with application if applicable) (date)