Client Services/Financial Aid Assistance

Application Coversheet

****CLIENT COPY-PLEASE READ, REMOVE AND KEEP, TURN IN APPLICATION SEPARATELY****

ADRC manages limited material aid funds. To access these funds:

- Please fill out the attached application front and back. Any applications received incomplete cannot be processed and will be returned to the client to be completed.
- Return applications to: 1129 Colorado Ave. Attn: ADRC 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.
- Once reviewed by the council, an ADRC options counselor will contact you of the decision made.

Application Information:

- It is the **client's responsibility** to get quotes for the service or item they are seeking and attach them with the application when they submit it for review.

****Applications cannot be processed without a quote****

- ADRC does **not** offer emergency services. The application process can take a week or longer if additional information is needed. Applications are reviewed on Friday mornings.
- There is no guarantee of services or assistance. Eligibility depends on funds available, need for care, functional status, age of caregiver (if one is involved), and the goals related to independence. Priority will be given to those individuals with the greatest social and/or economical needs.
- If capable, applicants can voluntarily contribute to the cost of services. Applicants cannot be denied services because of inability to contribute towards the cost of the service.

ADRC at this time does NOT help financially with the following material aid items:

- Car repair, home repairs, roof/floor repairs, medical bills, medications, utility bills, bus passes and phone bills.

*********All participants have the right to make a formal complaint. You may do so by contacting the Area Agency on Aging at 970-248-2717 or the State Unit on Aging at 303-866-2800.*********

ADRC of Mesa County
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:** _____ **Gender:** ☐ Male ☐ Female

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 (TANF)	_____	Food Assistance (Food Stamps)	_____
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 Food Stamps): _____

Other monthly expenses:

_____

_____

_____

What are <u>you</u> able to contribute to the cost of service?: _____

<u>Options Counselor or Case Manager Use Only:</u>			
I can eat without help.	☐Yes ☐No	I can manage money without help.	☐Yes ☐No
I can dress myself without help.	☐Yes ☐No	I can take care of shopping without help.	☐Yes ☐No
I can bathe myself without help.	☐Yes ☐No	I can take my medication without help.	☐Yes ☐No
I can use the toilet without help.	☐Yes ☐No	I can prepare meals without help.	☐Yes ☐No
I can get in & out of bed/chairs without help.	☐Yes ☐No	I can do ordinary housework without help.	☐Yes ☐No
I can get around inside my home without help.	☐Yes ☐No	I can use the telephone 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) (date)

_____ _____

(name of person assisting with application) (date)