Eligibility Determination and Request for Services Application

Department of Health and Social Services

Senior and Disabilities Services

FOR ASSISTANCE IN FILLING OUT THIS FORM;

Anchorage Office: Phone: 269-3666; Toll Free: 1-800-770-3930; Fax: 269-3624

Fairbanks Office: Phone: 451-5045; Toll Free: 1-800-770-1672; Fax: 451-5093

A. INFORMATION ON THE PERSON NEEDING SERVICES

1. Name: _____ _____ _____
   Last Name First Name M.I.

2. Address: _____ _____
   Street Address Mailing Address (if different)

   City: _____ State: __Alaska_____ Zip: _____

3. Telephone Number: (_____) _____ Message Number: _____

4. Sex: ( ) Male ( ) Female

5. Marital Status: ( ) Never Married ( ) Married ( ) Divorced

6. Date of Birth: _____ Place of Birth: _____ _____
   City State

7. Ethnicity:
   ( ) Alaska Native ( ) Caucasian
   ( ) African-American ( ) Hispanic
   ( ) Asian ( ) Other

8. Name of Legal Guardian: _____

9. Guardian's Address: _____

   City: _____ State: _____ Zip: _____

10. Home Telephone: _____ Work Telephone: _____

11. If you do not have a legal representative, please provide information below if there is anyone who assists you that you would like your mail to be copied to. **Please ensure this name is also listed on the release of information:**

    Name: _____ Relationship: _____

B. SERVICE INFORMATION

(All questions in this section are directed toward the person with disabilities who is requesting service.)

1. What services or supports do you need?

2. How soon do you need these services? Circle one:

☐ Now ☐ 6 months ☐ 1 year ☐ 2 years
☐ 3 years ☐ 4 years ☐ 5 years ☐ Other _____
Specify Date

3. What agencies or people in your community are helping you now?

4. Why are you requesting services at this time?

5. In what community will you need the services and supports you are requesting?

6. Are there any particular agencies or people you would like to provide the services and supports you need? Are there any special conditions you would like to place in these services?

7. Please check if the person needing services has received any of the following in the past six months.

- ☐ Medicaid coupons
- ☐ SSI (Supplemental Security Income) Amount $_____
- ☐ AD (Aid to the Disabled) Amount $_____
- ☐ Public Assistance Amount $_____
- ☐ Food Stamps

C. **FUNCTIONAL ASSESSMENT**

Describe the applicant's ability to perform the skills in the following areas of major life activity compared to a person of the same age who does not experience a disability (e.g., compare and contrast levels of independence, need for on-going support and assistance, etc.)

☐ 1. SELF CARE

What kind of assistance do you need, if any, for eating, dressing and toileting?

☐ 2. EXPRESSIVE & RECEPTIVE LANGUAGE

What is your primary means of communicating with others? Describe any special supports or assistance you use for communicating with other people.

☐ 3. LEARNING

What is the easiest way for you to learn new information and skills? Do you need extra help or support to make learning easier?

☐ 4. MOBILITY

Describe any special equipment or assistance you need to move from one place to another at home, work, school, or in the community.

☐ 5. SELF DIRECTION

What kinds of decisions are you able to make on your own? Describe any support or assistance you rely on to help make decisions, or get through your daily routine.

☐ 6. CAPACITY FOR INDEPENDENT LIVING

(Only applies if age 16 years or older)

What supports do you need to live independently in your own home, do your own shopping, meal preparation, home maintenance, scheduling and keeping appointments, etc.

☐ 7. CAPACITY FOR ECONOMIC SUFFICIENCY

(Only applies if age 16 years or older)

What assistance is necessary for you to support yourself with income from a job, or through subsistence activities?

D. ELIGIBILITY FOR SERVICES

In order to assist in determining eligibility, please attach assessments, medical evaluations, etc.

For determining the eligibility for people six years and older, a recent school or psychological evaluation that includes a full scale I.Q. score (for people who experience intellectual disability) is requested. For disabilities other than intellectual disability, a physician' statement or evaluation may be used, as well as special education evaluations, and/or other comprehensive evaluations that document the existence of a disability which occurred prior to the age of 22 and is likely to last indefinitely.

**** Applications submitted without supporting documentation of disability, or a signed information release cannot be processed within normal time frames, and will be returned.**

1. Please list any mental or physical impairment or combination of physical and mental impairments that have occurred before age 22, that are likely to continue indefinitely, and result in substantial functional limitations in three or more areas of major life activity.

E. INFORMATION RELEASE AND ASSURANCES

You will need to complete a separate release of information for each agency or individual from whom you wish Senior and Disabilities Services to obtain

Note: Failure to provide consent to release information will not prohibit provision of services to eligible individuals. It may however substantially delay the Division's determination of eligibility.

I certify that the information contained herein is correct and accurate to the best of my knowledge.

Applicant or Guardian Signature: _____

Date: _____

The individual experiencing a disability or guardian will receive a written determination of eligibility for services and confirmation. If you feel an error was made in the eligibility determination, contact Senior and Disabilities Services, Health Program Manager III within 30 days of receipt of the written eligibility determination to initiate an appeal.

STATE USE ONLY

DD Staff use: ID ☐ Autism ☐ CP ☐ Epilepsy ☐

Eligible Per AS 47.80.900 Prior to 7/28/92 Yes ☐ No ☐

	ICD-9-CODE	Date of Onset M D Y
1.	☐☐☐.☐☐	☐☐ ☐☐ ☐☐
2.	☐☐☐.☐☐	☐☐ ☐☐ ☐☐
3.	☐☐☐.☐☐	☐☐ ☐☐ ☐☐
4.	☐☐☐.☐☐	☐☐ ☐☐ ☐☐

Applicant Name: _____

Date Determined Eligible: _____

Date Eligibility Denied: _____

Health Program Manager
Signature: _____

Date Eligibility Determination Letter Sent: _____

State of Alaska

Department of Health and Social Services
Division of Senior & Disabilities Services
550 West 8th Ave ● Anchorage, Alaska 99501
(907) 269-3666 ● 1-800-478-9996

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____

Record # or Other ID: _____ Date of Birth: _____

Other Names under which records might be filed: _____

Person/Organization Releasing Information: _____

Person/Organization Receiving Information: _____

_____

Description of Information to be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)*

_____

_____

The purpose of the release of this information is: _____

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information *may* condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: _____

_____ _____
Signature of Client or Personal Representative (Or Witness if signature is by mark) Date

_____ _____
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see reverse or attached revocation statement)*
Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

REVOCATION SECTION

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____.
(Date)

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Client or Personal Representative Date
(Or Witness if signature is by mark)

_____ _____
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority

_____
Signature of Staff