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Powering Independent Living

Please find the enclosed information on the Independent Living Services Program.

The program is funded through the State of Maine's Division of Vocational Rehabilitation. It enables people with disabilities to live independently in the community. This program is a fund of last resort, and may be applied for when there are no other funding options to meet your independent living needs.

If you wish to apply for these services, please complete this application and information release forms. These must be completed entirely so that we may process them as quickly as possible.

When your application is received, we will contact you to set up an appointment to discuss your eligibility and your independent living needs. We will determine your Priority Status for the Waiting List under Order of Selection rules. When your name comes to the top of the waiting list, we will contact you again to work with you to identify and purchase your products or services.

Return the application to the office nearest you.

127 Main Street
S. Portland, ME 04106

207-767-2189
800-640-7200
207-799-8346 (Fax)

11 Bangor Mall Blvd. Unit A,
Bangor, ME 04401

207-941-6553
800-300-6016
207-941-6410 (Fax)

66 Spruce Street
Presque Isle, ME 04769

207-764-6466
800-974-6466
207-764-5396 (Fax)

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Independent Living Services Program Application

Name ..... **SS#** .....

Address: ..... **Date of Birth** .....

..... **Age** .....

County: ..... **Male** ☐

Phone: ( ) ..... **Female** ☒

E-mail: .....

Disability: ..... Date of Onset: .....

Describe how your disability limits your ability to function: .....

.....

Are you in danger of losing your current level of independence and being required to move to a more restrictive setting?
☐ Yes ☐ No. *If Yes Please Explain*: .....

.....

Do you have any specific adaptive equipment products or independent living services in mind? *Please list equipment and approximate cost (if known)* . .....

.....

How will these independent living services or adaptive equipment products improve your independence, productivity, or quality of life? .....

.....

Have you applied for this program before? ☐ Yes ☐ No *If Yes, when?* .....

I agree to participate to the best of my ability in:

☐ Determining my needs for services and/or products ☐ Selecting and purchasing services and/or products

☐ Being trained on the use of my adaptive equipment products or participating in an IL service

☐ Initiating and maintaining regular contact with Alpha One staff and to keep scheduled appointments

☐ I understand that I am encouraged to participate financially to the best of my ability.

☐ I understand that a priority system is used to determine the use of these funds and I may be placed on a waiting list.

I am my own guardian. ☐ Yes ☐ No *If No who is?* **Name:** .....

Address: .....

.....

Phone: ( ) .....

Email: .....

This is an accurate statement of my disability related needs to the best of my knowledge

Applicants Signature: ..... Date: .....

Signature of Guardian (or if under age18) ..... Date: .....

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Financial Eligibility Information Form

To determine if you meet the financial eligibility criteria for Independent Living Services Program please complete the following worksheet:

Please check where appropriate and fill in amounts of your monthly household income.

Monthly Income:		**Check if you have the following:**	
Source	**Amount**	☐	Medicare A #
Employment Gross Wage	$	☐	Medicare B #
SSDI	$	☐	MaineCare #
SSI	$	☐	Private Health Insurance (Name)
Social Security	$		
Pensions	$	☐	VA Benefits
VA Benefits	$	☐	Other:
Other:	$		

If you have any of the following please list below.

Checking or Savings Account •Credit Union Shares •IRA, 401K, Keogh •CD's Stocks & Bonds •Trust Fund •Annuities •Prepaid Burials •Profit Sharing •Other Accounts

Type of Asset (See Above)	**Current Balance or Value**

If you have any of the following please list below.

☐ Your Home?
☐ Any other land or buildings? *Type of Real Estate:*
☐ Any personal property such as boats, campers, ATV's, etc.. *Please List:*

I hereby certify that the above statements are true. I acknowledge that any misrepresentation of facts or figures in this application constitutes fraud and could result in repayment of funds received.

Applicants Signature: Date:

Signature of Guardian (or if under age18) Date:

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Release of Information Authorization

Provider's Name: .....

Check One: ☐ Physician or Medical Specialist ☐ Other: .....

Address: .....

.....

Phone: ( ) .....

Consumer's Name: .....

Social Security # : ..... **Date of Birth:** .....

Are you receiving services through any other organization, or MaineCare?

Service Name: .....

Case Manager: ..... **Contact:** .....

Requested Document(s): Documents indicating the consumer's disability or functional needs for adaptive equipment or independent living services.

Other documents needed: .....

.....

These documents are held confidential and are used to determine eligibility for the Independent Living Services Program as administered by Alpha One. Information may be released and exchanged between the Division of Vocational Rehabilitation and Alpha One.

I understand that the records requested may contain sensitive information and I may refuse authorization to disclose all or some of this information. I understand that refusal may result in improper eligibility determination.

This release is subject to revocation by written request by the named individual at any time and will expire one year from the date it was signed, or when the purpose of this release has been met, whichever is sooner. I can request a copy of this release for my records.

By signing below I authorize the release of copies of information or medical records to ALPHA ONE
127 Main Street South Portland, ME 04106

....

Consumer or Authorized Representative Signature Relationship Date

ALPHA ONE - PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO EXPLAINS HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that privacy is a very important matter. Our work requires us to gather your personal health information (PHI) in order to provide services. We create a record of the services that you receive and you can trust us to keep your records confidential and secure.

Collecting Information: We collect personal health and insurance information about you in order to provide you with services. Under State and Federal Law we are required to protect the privacy of your personal health information (PHI).

Confidentiality and Security: We restrict access to your PHI only to employees who need the information to provide you with services. We maintain physical, electronic and procedural safeguards to comply with all laws and regulations to protect the privacy of your PHI.

Information Use: We do not sell your PHI to outside mailing lists or telemarketing companies. We will add your name to Alpha One's own *One in Five* Newspaper mailing list in order to provide you with information on disability related services and products. We will contact you to schedule appointments or discuss services via the telephone, e-mail, or postal mail. You can specify the way you want us to communicate if it is necessary to protect your interests.

Information Disclosure: We use and disclose your PHI so that our staff can provide you with Services and/or **Treatment**, to obtain **Payment** and to perform service delivery **Operations** (TPO). We review your PHI so that we can determine your program eligibility and sources of funding. The PHI that is disclosed may include: your name, address, social security number, phone number, diagnosis and disability, the name of your insurance provider, the insurance policy and coverage, reports/contact notes and co-payments.

Any other use or disclosure of your information (for Non-TPO purposes as described above) will require your written authorization. If you end your business with us, we will continue to restrict use of you personal health information as if you were still a consumer.

Your Rights: You have the right to restrict our use of your personal health information, to review and copy your record information, to request changes to your information, to find out who we have disclosed your information to, and to file a complaint about our Privacy practices. If you file a complaint, we will take no action against you or change your services in any way. To file a written Privacy complaint contact Dennis Fitzgibbons at 127 Main St. South Portland ME 04106 **1-800-640-7200 (v/tty)**
We reserve the right to amend this notice at any time.

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Effective April 14, 2003

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CONSENT FORM

FOR THE USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby consent to the use and disclosure of my personal health information (PHI) by Alpha One in order to carry out services/treatment, payment or health care operations. I have reviewed Alpha One's Privacy Notice and have a copy of that notice.

I have the right to request that the use and disclosure of my PHI be limited for only services/treatment, payment and operations. I can revoke this Consent at any time by written request. I understand that Alpha One may refuse to provide me with services if I do not sign this Consent.

I have received and understand this information. I have received a copy of this Form and agree to the stated terms.

Date_____**Time**____am/pm

Consumer Name (printed) _____

Consumer Signature _____

Personal Representative _____

Alpha One, 127 Main St South Portland, ME 04106 Tel: 207-767-2189 (v/tty) Fax: 207-799-8346