INDEPENDENT LIVING SERVICES
PROGRAM APPLICATION

ALPHAONE
DISABILITY + AGING SOLUTIONS

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 address below
or send via email to info@alphaonenow.org

Alpha One
PO Box 1870
Portland, ME 04104

Tel: 800-640-7200
Fax: 207-799-8346

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Name

Social Security Number

Address Line 1

Date of Birth

Address Line 2

Age

County

Gender

Phone

Email

Disability

Date of Onset

Are you in danger of losing your current level of independence and being required to move to a more restrictive setting? If yes, please explain.

What adaptive equipment, products, or services are being requested? Please list equipment and cost (if known).

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

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What other funding sources, organizations or agencies have you applied for before applying to this grant? (Please also note the date you applied and the outcome)

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

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- ☐ 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 Phone

Address

Email

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

Applicant's Signature Date

Guardian's Signature Date

INDEPENDENT LIVING SERVICES
FINANCIAL ELIGIBILTY

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

Monthly Income

Employment Gross Wage	$
SSDI	$
SSI	$
Social Security	$
Pensions	$
VA Benefits	$
Other	$
Describe Other	

Check if you have the following.

- ☐ Medicare A #
- ☐ Medicare B #
- ☐ MaineCare #
- ☐ Private Health Insurance (Name)
- ☐ Other (Describe)

If you have any of the following, please list below.
Checking or Savings Account • Credit Union Shares • IRA • 401K • Keogh • CDs • Stocks • Bonds • Trust Fund • Annuities • Prepaid Burials • Profit Sharing • Other Accounts

Type of Asset (See above)	Current Balance or Value

Check if you own the following.

☐ Home/Primary Residence ☐ Other Land/Buildings ☐ Other Personal Property (list below)

Boats, Campers, ATVs, etc.

Applicant's Signature

Date

Guardian's Signature

Date

INDEPENDENT LIVING SERVICES
RELEASE OF INFORMATION AUTHORIZATION

ALPHAONE
DISABILITY + AGING SOLUTIONS

Provider's Name

Provider's Role (Physician, etc.)

Address Line 1

Address Line 2

Provider's Phone

Consumer's Name

Date of Birth

Social Security Number

Are you receiving services through any other organization or MaineCare?

Service Name

Case Manager

Contact Info.

Requested Documents: 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 DISABILITY + AGING SOLUTIONS.

Consumer or Authorized Representative Signature (and Relationship)

Date

INDEPENDENT LIVING SERVICES
PRIVACY NOTICE

ALPHAONE
DISABILITY + AGING SOLUTIONS

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 Tom Newman 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.

INDEPENDENT LIVING SERVICES
CONSENT FORM

ALPHAONE
DISABILITY + AGING SOLUTIONS

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.

Consumer Name (Printed) | Date | Time ☐ AM ☐ PM

Consumer Signature (or see below for representative/guardian)

Personal Representative Name (Printed) | Date | Time ☐ AM ☐ PM

Personal Representative Signature

Authorization to Release Information

We are committed to the privacy of your health information.
Please read this form carefully.

☐ Office of MaineCare Services	☐ Substance Abuse and Mental Health Services
☑ Office for Family Independence / Medical Review Team	☐ Office of Child and Family Services
☐ Maine Centers for Disease Control and Prevention	☑ Office of Aging and Disability Services
☐ Dorothea Dix Psychiatric Center	☐ Office of Administrative Hearings
☐ Riverview Psychiatric Center	☑ Other: Alpha One (SCA)
☑ Other: Assessing Services Agency (ASA)	☐ Other: EIM (SCA)
☑ Other: SeniorsPlus Specialized Services	☐ Other: Catholic Charities (SCA)

Individual's Name:_____Individual's Date of Birth: _____
Individual's Address:
Street: _____

Town/City:_____State:_____Zip Code: _____

I authorize the DHHS offices and/ or other agencies checked above to:
☑ **Release my information to:** ☑ **Obtain my information from:** ☑ **Discuss my information with:**

☐ Adult Day Services	☐ Home Health Agencies	☐ Nursing Facilities	☑ Transportation Agencies
☐ Area Agencies on Aging	☐ Hospital(s)	☐ Personal Care Provider(s)	☑ Vocation Rehabilitation
☐ Alzheimer's Respite Program	☐ ICFs	☑ Physician(s)	☑ Waiver Services Provider
☐ Assessing Services Agency(s)	☐ Long Term Care Ombudsman	☑ Residential Care Facilities	☑ Dual Special Needs Plan
☐ Case Management Agencies	☐ Neurorehabilitation Clinics	☑ Service Coordination Agency(s)	☐ Other _____

☐ Homemaker ☐ Neurorehabilitation ☑ Social Security Administration ☐ Other _____

EMAIL: If requesting that electronic information be transmitted by email, please clearly print the email address below:

_____

I understand that the agencies above may not be able to send my information securely through email. I understand that email and the internet have risks that cannot be controlled and that the information possibly could be read by a third party. I accept those risks and still request that my information be sent by email. Initials_____

PURPOSE: The office(s) or agencies named above may disclose or share my information for the following purpose(s):

- ☑ For a legal matter, including an administrative hearing
- ☑ To see if I qualify for insurance coverage or benefits
- ☑ To coordinate my care and/or benefits
- ☑ A personal request
- ☑ Other (note here):_____

General permission:	**Special permission**: **Drug/Alcohol Referral or Services**
☐ **All** health information from the DHHS office(s) checked above ☐ Claims or encounter data (information about visits to health care providers) ☐ Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits ❒ Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017") _____ ❒ Other:_____	❒ Include **all** drug/alcohol information in the release ❒ Include only the **specific** drug/alcohol records checked: ❒ Diagnosis and treatment ❒ Clinical notes and discharge summaries ❒ Drug/Alcohol history or summary ❒ Payment or claims information ❒ Living situation and social supports ❒ Medication, dosages or supplies ❒ Lab results ❒ Other: _____
Special permission: Mental/Behavioral Health Services ❒ Include this information in the release ❒ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. **Please note**: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ❒ Include this information in the release **Please note**: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

I (individual/personal representative of individual) permit the office(s) or agencies checked on this form to release and/or obtain my records as written on Page 1 of this form. I understand and agree to the following:

- This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner. To take back my permission from DHHS, I will complete, sign and send in the Revocation Form found on the DHHS website at http://www.maine.gov/dhhs/privacy/index.shtml to the office that provides me with services. To take back my permission from a non-DHHS agency, I will call that agency directly. I may call DHHS-OADS at 207-287-9200 and ask for the Privacy Liaison in the office that provides me with services if I need help revoking this form.
- I understand that taking back my permission to release my information does not apply to the information that was already shared after I signed this form.
- I agree that additional sharing of my information may occur until this form expires or I take back my permission.
- If I take back my permission to release information, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- This form permits the people or offices checked on Page 1 to speak to each other for the purpose(s) on this form.

- If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.

- Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.

- I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.

- If I want to review my mental health program or provider records before they are released, I must check **THIS BOX ☐** . I understand that the review will be supervised.

- My information will be kept confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.

- If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.

- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date:_____ Signature_____

Personal Representative's authority to sign:_____