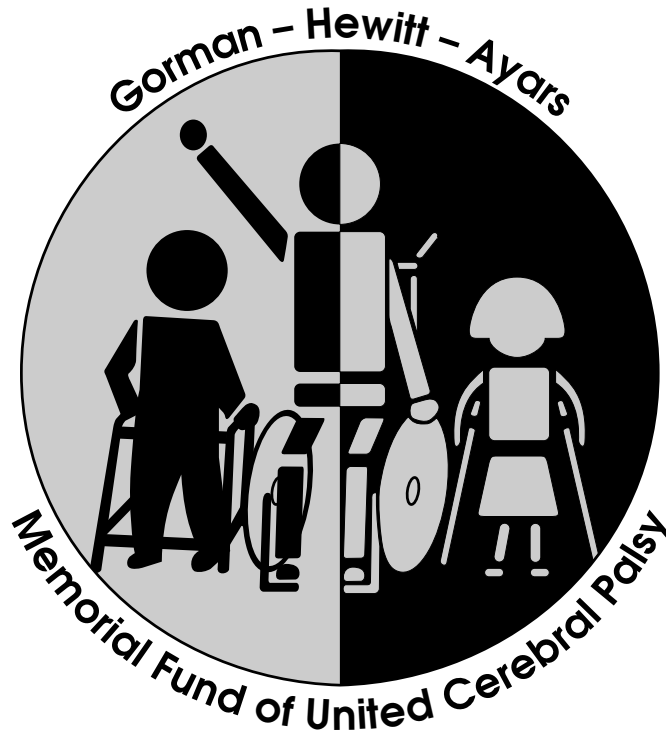


**Application
for Eligibility
Determination**

Date _____



A better life for those with
physical disabilities.

Personal Information of Those Who Will Receive Services

Name of individual with disability _____

Address _____ City _____ Zip _____ County _____

Home telephone () _____ Alternate telephone () _____ Male/Female _____

Date of birth _____ Social security number _____ - _____ - _____ Parent or guardian _____

Nature of disability _____

Medical Information

Please check all that apply to the person's disability. If you need additional space, use the lines provided below.

- | | | |
|--|---|--|
| <input type="checkbox"/> Amputee | <input type="checkbox"/> Chronic Osteomyelitis (bone disease) | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Ankylosis (joint disease) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Spina-bifidia |

Additional space _____

List any special equipment needs (crutches, braces, wheelchair, communication aid, helmet, etc...) _____

Equipment needed at this time _____

Family doctor name _____

Address _____ City _____ Zip _____ Telephone () _____

Insurance Information

Insurance type (Medicaid/Medicare, other) _____

Insurance company name _____

Address _____ City _____ Zip _____ Telephone () _____

Identification no. (Medicaid/Medicare, other) _____ Percent of coverage (insurance) _____

1) Do you have a current application on file with your local County Board of Mental Retardation and Development Disabilities? Yes No

If yes, please list contact person's name _____

2) Have you received services or equipment from your local County Board of Mental Retardation and Development Disabilities in the past? Yes No

If yes, please indicate the month/day/year received _____

3) Do you currently have a doctors prescription for requested services or equipment? Yes No

If yes, please explain _____

4) Are you currently enrolled in school, habilitation, workshop, or a training program? Yes No

If yes, please give name _____ Address _____

5) Has individual ever been evaluated? Yes No

If yes, who did the last evaluation _____ Date _____

Insurance Information (continued)

Please list all the individuals who live with the disabled person.

| Name | Relationship | Age | Male/Female |
|------|--------------|-----|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Income Certification

I hereby certify that my taxable income was \$ _____ for _____ (enter prior year)
 Signature (applicant, parent or guardian) _____ Date _____

OR

I did not have any taxable income for last year, which was _____ (enter prior year)
 My only source of income is _____ (SSA/SSI, ADC, etc..) Amount received per month \$ _____
 Signature (applicant, parent or guardian) _____ Date _____

I certify that the information on this application is correct. I understand that the Gorman – Hewitt – Ayars Memorial Fund has the right to verify the information given by me on the application and may require documentation to verify disability or income eligibility. A home visit may be made by a designee of the Gorman – Hewitt – Ayars Memorial Fund to assure that requested services and equipment are appropriate and meet quality standards.

I also agree that the Gorman – Hewitt – Ayars Memorial Fund has permission to share information pertaining to the disabled individual with vendors and/or agencies when needed, to provide for services and equipment.
 Signature (applicant, parent or guardian) _____ Date _____

Office Use Only

Date received _____ Co-payment amount _____
 Date approved _____ Verification letter sent _____

Notes: _____

