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:** _____ **Primary Language:** _____

Race/Ethnicity:
- ☐ African American
- ☐ Hispanic/Latino
- ☐ American Indian/Alaskan Native
- ☐ White
- ☐ Asian/Pacific Islander

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Other

Type of Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ None
- ☐ Private/Other(Please describe)

_____

Are you a veteran?
- ☐ Yes
- ☐ No

Gender?

_____

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
- ☐ Long Term Care Facility
- ☐ Other (Please Describe)

_____

Do you use any of the following?
- ☐ Denture
- ☐ Hearing aids
- ☐ Glasses/Contacts
- ☐ Assistive Devices (Please Describe)

_____

Do you have a disability or illness that affects your daily life? If so, check all that apply:

- ☐ Developmental Disability
- ☐ Physical Disability
- ☐ Mental Illness
- ☐ Dementia
- ☐ Traumatic Brain Injury
- ☐ Hearing Disability
- ☐ Visual Impairment
- ☐ Other: _____

What type of service or materials are being requested? _____

Please explain in detail why this assistance is needed:

_____

_____

_____

_____

_____

_____

Monthly Household Finances:

Source of Income (Ex: Social Security, employment, child support, etc.): _____

Monthly Income Amount: $_____ **Do you receive Food Assistance?** ☐ Yes ☐ No

Monthly Household Expenses:

Rent/Mortgage: $_____ Water/Sewer: $_____ Gas/Electric: $_____ House/Cell Phone: $_____

Auto/Car Payment: $_____ Life Insurance: $_____ Health Insurance Premium: $_____

Auto/Car Insurance: $_____ Pharmacy: $_____ Food (not including Food Stamps): $_____

Other monthly expenses:

_____

_____

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

The following questions are optional, but they help our team provide better options counseling, if left blank our team my ask for additional information:

Do you eat fewer than 2 meals per day?	☐Yes ☐No	Are you physically able to feed yourself?	☐Yes ☐No
Do you eat few fruits, vegetables or milk products?	☐Yes ☐No	Do you have difficulty bathing yourself?	☐Yes ☐No
Do you eat alone most of the time?	☐Yes ☐No	Do you have difficulty dressing yourself?	☐Yes ☐No
Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	☐Yes ☐No	Do you struggle using the bathroom on your own?	☐Yes ☐No
Do you have 3 or more drinks of beer, liquor or wine almost every day?	☐Yes ☐No	Do you struggle getting in and out of bed/chairs?	☐Yes ☐No ☐Yes ☐No
Do you have tooth or mouth problems that make it hard for you to eat?	☐Yes ☐No	Do you struggle getting around at home?	☐Yes ☐No
Are there times you do not have enough money to buy the food you need?	☐Yes ☐No	Can you manage money without help?	☐Yes ☐No
Do you take 3 or more different prescribed or over the counter drugs a day?	☐Yes ☐No	Can you do your shopping without help?	☐Yes ☐No
Without wanting to, have you lost or gained 10 pounds in the last 6 months?	☐Yes ☐No	Can you take medications without help?	☐Yes ☐No
		Can you use the telephone without help?	☐Yes ☐No
		Can you prepare meals without help?	☐Yes ☐No
		Can you do ordinary housework 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 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)