



DATE: _____

NAME: _____ DOB: _____
 LAST FIRST MIDDLE

ADDRESS: _____
 STREET CITY STATE ZIP COUNTY

TELEPHONE: _____ SOCIAL SECURITY NUMBER: _____ SEX: _____

DISABILITY CODE: _____

DESCRIPTION: _____

CHECK ALL THAT APPLY:

CURRENTLY EMPLOYED (16 HOURS OR MORE PER WEEK) - EMPLOYER: _____

HIRED TO BEGIN WORKING: _____

SEEKING EMPLOYMENT

IN SCHOOL OR TRAINING: WHERE: _____

COURSE: _____ HOURS: _____ COMPLETION DATE: _____

LIVE INDEPENDENT

ARE YOU CURRENTLY ELIGIBLE FOR MEDICAID? YES NO MEDICAID NUMBER: _____

DO YOU HAVE A SPEND DOWN? YES NO MONTHLY AMOUNT: \$ _____

CURRENT LIVING ARRANGEMENT – CHECK ALL THAT APPLY:

PRIVATE HOME

APARTMENT

GROUP HOME

NURSING HOME

SPECIAL HOUSING: _____

LIVE ALONE

LIVE WITH ATTENDANT

LIVE WITH SPOUSE AND CHILDREN

LIVE WITH PARENTS AND OTHER FAMILY

LIVE WITH OTHER ADULTS

LIST NAMES AND RELATIONSHIPS OF ADULT FAMILY MEMBERS WHO LIVE WITH YOU: _____

DO YOU PLAN TO CHANGE YOUR LIVING SITUATION IN THE NEAR FUTURE: YES NO

IF YES, PLEASE EXPLAIN: _____

ARE YOU CURRENTLY RECEIVING SERVICES THROUGH THE DIVISION OF VOCATIONAL REHABILITATION, OR THE DEPARTMENT OF HEALTH AND SENIOR SERVICES, OR HAVE YOU IN THE PAST? YES NO

VR OFFICE: _____

MENTAL HEALTH: _____

DHSS: _____

OTHER: _____

ARE YOU CURRENTLY USING ATTENDANT CARE SERVICES? YES NO

IF YES, PLEASE EXPLAIN (HOW MANY HOURS, WHO PAYS FOR SERVICES, ETC.): _____

WHEN WOULD YOU WANT SERVICES FROM THIS PROGRAM TO BEGIN? _____

DATE DISABILITY BEGAN: _____ AGE DISABILITY BEGAN: _____

PHYSICIANS NAME (REQUIRED): _____

PHYSICIANS TELEPHONE NUMBER: _____

My signature below indicates that I am applying for Attendant Care services and that I understand the information given will be held confidential and will be used only by the Missouri Division of Vocational Rehabilitation (MDVR) and by other agencies working with MDVR in providing services to me. I understand that the services of this program are provided without discrimination. In addition, I understand that I should direct any comments, questions, or complaints about my application or about services under the program to the agency or organization through which services are coordinated in my community.

APPLICANT'S SIGNATURE: _____

