ASSISTIVE DAILY LIVING SERVICES PROGRAM
2007 Application
Expires December 31, 2007

Complete and return to:

Denise White
Division of Rehabilitation Services
E Hwy 34 Hillsview Plaza
500 E Capitol
Pierre, SD 57501

This Assistive Daily Living Services program may provide case management services, consumer preparation services, lifeline, private duty nursing and personal attendant services. Please answer these eligibility requirements.

1. I am at least 18 years old…….....____**Yes** ____**No**
2. My 2007 income is less than $1,869 per month ……...____**Yes** ____**No**
3. I own less than $2,000 of assets (does not include one home or one automobile) ____**Yes** ____**No**
4. I have a substantial functional impairment to all four limbs due to ataxia, cerebral palsy, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, traumatic brain injury, a congenital condition, an accident or injury to the spinal cord, or other neuromuscular or cerebral (other than traumatic brain injury) condition or disease; or has four limbs absent due disease, trauma or congenital conditions…….____**Yes** ____**No**
5. As a result of my disability, I need assistance with activities of daily living i.e. dressing, bathing, toileting, preparing meals……...____**Yes** ____**No**
6. I am able to independently manage and direct a personal attendant (and included recruiting, screening, interviewing, selecting, scheduling, training, supervising, preparing timesheets, arranging for emergency backup, determined the attendance competency to perform need services, direct the attendant to due to tasks, resolve conflicts, and, if necessary, terminate the attendant if the conflict can not be resolved…….... ____**Yes** ____**No**
7. I am medically stable and free from life-threatening conditions as determined by the individual's personal physician……...____**Yes** ____**No**

8. Who is currently caring for my unmet daily living needs? _____

_____

_____

I understand that it is my responsibility to complete the information requested and submit it to the address above so that I may be considered for services. I understand that if I answer yes to all the questions listed above I will receive an assessment to determine my eligibility for services. I also understand that if after the assessment I am not found eligible for services, I will be notified in writing of my right to appeal the determination and to request a fairing hearing.

Print Name Signature Date

Street City State Zip Phone Number

My Disability is?