APPLICATION
ASSISTIVE DAILY LIVING SERVICES PROGRAM
Expires December 31, 2017

Complete and return to:

ADLS Waiver Manager
Division of Rehabilitation Services
3800 E. Hwy. 34, Hillsview Plaza
c/o 500 E Capitol Ave.
Pierre, SD 57501

This Assistive Daily Living Services program provides personal attendant services, consumer preparation services, lifeline, in-home nursing, specialized medical equipment and supplies, environmental accessibility adaptations, respite, vehicle modifications and incontinence supplies to eligible individuals.

Please answer these eligibility requirements:

	YES	NO
1. I am at least 18 years old.		
2. My 2016 income is less than $ 2,205 per month.		
3. I own less than $ 2,000 of assets (does not include one home and one automobile) or $26,180 in combined assets (if married).		
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 have four limbs absent due to disease, trauma or congenital conditions.		
5. As a result of my disability, I need assistance with activities of daily living i.e. dressing, bathing, toileting, preparing meals.		
6. I am able to independently manage and direct a personal attendant (includes recruiting, screening, interviewing, selecting, scheduling, training, supervising, preparing timesheets, arranging for emergency backup, determine the attendance competency to perform needed services, direct the attendant to perform tasks, resolve conflicts, and, if necessary, terminate the attendant if the conflict cannot be resolved) OR select a representative to manage and direct my services on my behalf.		
7. I am medically stable and free from life-threatening conditions as determined by the individual's personal physician.		

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. I authorize the Division of Rehabilitation Services to gather information to determine eligibility and to assist in determining services needed. Exchange of information may include cooperating with other Departments in state government, contract providers, long term care facilities, hospitals, rehabilitation facilities, and home health agencies.

Print Name Disability Date of Birth

Street City State Zip Phone Number

Applicant Signature Date