Maryland Department of Disabilities
Attendant Care Program

The Maryland Attendant Care Program reimburses eligible persons with disabilities for a portion of their attendant care costs.

Eligibility Criteria. To be eligible for the program, YOU MUST:

1. Be a Maryland resident; **and**
2. Be between the ages of 18 and 64 (at the time of initial eligibility determination); **and**
3. Be determined and certified by your physician to have a severe disability that keeps you from performing essential activities of daily living, self-care, and mobility; **and**
4. Not be receiving duplicative attendant care services; **and**
5. Have a total gross income (taxable and non-taxable) of less than $119,999 per year;

---------------AND---------------

6. You must be employed; **or**
7. You must be actively seeking employment; **or**
8. You must be enrolled in an institution of post secondary or higher education; **or**
9. You must be a nursing facility resident who would be able to reside in the community if attendant care is provided; **or**
10. You must be at risk of nursing facility placement if you do not receive attendant care services in the community.

General Application Instructions. To apply for the Attendant Care Program YOU MUST:

1. Complete pages 2-8 of this application packet accurately.
2. Submit all signatures required in this application packet.
3. Submit proof of eligibility, where required, as outlined in this application packet.
4. Have your doctor or registered nurse complete and sign the Standard Assessment of Functional Capability Forms (pages 1-3 of separate packet).
5. Complete and sign the Authorization for Release of Records and Information on page 8 of this application packet.
6. **If you are a designee or authorized representative** for the applicant, you must include proof that you are authorized to apply on the applicant's behalf. See page 7 of this application packet for acceptable forms of proof.

SECTION 1: APPLICANT INFORMATION

____ ______-______-_________
Name Social Security No.

___/___/______ ________ (_____)_____-__________ ___________________
Date of Birth Age Telephone Number Marital Status

____
Street Address

____
City County State Zip Code

____ I have enclosed proof of my age (such as a copy of my driver's license or birth certificate) AND proof of Maryland residency (such as a copy of my utility or telephone bill).

I am currently enrolled in or eligible for the following program(s):

___ In-Home Aide Services (IHAS)
___ MEDICARE ___ Part A __ Part B ___ Part D (Prescription Plan)
___ Qualified Medicare Beneficiary (QMB)
___ Specified Low-Income Medicare Beneficiary (SLMB)
___ Medical Assistance (MA)
___ Medicaid Waiver ___ Older Adults Waiver ___ Living at Home Waiver
___Medicaid Personal Care (MAPC)

____ I am not currently enrolled in any of the above programs.
____I do not know if I am enrolled in or eligible for any of the above program(s).

I AM: (Choose all that apply)

____ Currently employed.

____ Currently looking for work.

____ Currently attending an institution of post secondary or higher education.

____ Residing in a nursing facility and able to reside in the community if attendant care is provided.

____ At risk of going into a nursing facility if attendant care services are not received in the community.

____ None of the above.

NAME OF APPLICANT: ___________________________________DATE OF APPLICATION: _______

SECTION 2: CURRENT EMPLOYER INFORMATION

____ Not applicable (I am not currently employed).
SKIP TO NEXT BOX

______________________________ ___________ ___________ $____________
My Job Title/Occupation # hrs./week Weekly Salary

_________________________________ ___/___/___ (____)______-_________
Employer Name Start Date Employer Phone Number

____
Employer Street Address

____
City County State Zip Code

SECTION 3: JOB-SEEKING ACTIVITIES

____ Not Applicable (I am not currently looking for a job).
SKIP TO NEXT BOX

____ The following information shows recent attempts I have made to find a job:

____ I have enclosed a copy of my resume.

Date of Contact	**Employer Name and Address**	**Result of Contact**

NAME OF APPLICANT: ___________________________________DATE OF APPLICATION: _______

SECTION 4: NURSING FACILITY INFORMATION

_____ Not applicable (I am not currently living in, nor on a waiting list for placement in a nursing facility).
SKIP TO NEXT BOX

____ I currently **(circle one)** live in/am on a waiting list for placement in the following nursing facility:

____ (_____)_______-___________
Nursing Facility Name Facility Telephone Number

____
Nursing Facility Street Address

____
City County State Zip Code

SECTION 5: VERIFICATION OF RISK OF NURSING FACILITY PLACEMENT

____ Not applicable (I am not currently at risk of nursing facility placement).
SKIP TO NEXT BOX

____ I have enclosed a signed letter from my physician, on my physician's business letterhead, stating that I am at risk of nursing facility placement if I do not receive attendant care services in the community.

SECTION 6: SCHOOL ENROLLMENT INFORMATION

____ Not Applicable (I am not currently attending an institution of post secondary or higher education).
SKIP TO NEXT BOX

____ I am enrolled in the following post secondary/higher education institution:

____ ______________________________
Name of Institution Date of Enrollment

____
Address

______________________ ____________________________ _________________________
Number of Credits earned Number of current Credits/Courses Declared Major of Study

____ I have enclosed proof of enrollment (a class schedule or letter from the school's Registrar office indicating my name, social security number and the dates of enrollment).

SECTION 7: I WOULD LIKE THE FOLLOWING PERSON(S) TO BE MY ATTENDANT:

____ I understand that any attendant I choose must be at least 18 years of age and may not be my spouse.

ATTENDANT 1:

______________________________________ ________________________________
Name Attendant's Relationship to Me

_____/_____/________ ________ (_____)_____-___________
Date of Birth Age Telephone Number

____
Street Address

____
City County State Zip Code

ATTENDANT 2:

______________________________________ ________________________________
Name Attendant's Relationship to Me

_____/_____/________ ________ (_____)_____-___________
Date of Birth Age Telephone Number

____
Street Address

____
City County State Zip Code

ATTENDANT 3:

______________________________________ ________________________________
Name Attendant's Relationship to Me

_____/_____/________ ________ (_____)_____-___________
Date of Birth Age Telephone Number

____
Street Address

____
City County State Zip Code

____ I have not yet chosen an attendant but I understand that any attendant I choose must be at least 18 years of age and may not be my spouse.

SECTION 8: MY AND/OR MY SPOUSE'S INCOME WORKSHEET

(A) **Total Adjusted Gross Income** from my most recent IRS Tax Form $______________________

____ **I have attached a copy of my most recent federal (IRS) and State Tax Forms.**

Total Adjusted Gross Income from my spouse's most recent IRS Tax Form $______________

____ **I have attached a copy of my spouse's most recent Federal and State Tax Forms.**

---------------OR---------------

(B) **Income Tax Filing Status Declaration**

I, ___________________________________, and/or my spouse, _______________________________, in accordance with the Internal Revenue Service Regulations, am/is/are not required to file an Income Tax Return for the year ending December 31, ________, due to insufficient income.

The above statement is accurate to the best of my knowledge.

___________________________________ ___________________
Applicant's Original Signature Date

___________________________________ ___________________
Spouse's Original Signature Date

Spousal signature only required if the spouse is not required to file an Income Tax Return.

(C) Annual Gross Income (Select all that apply)	
____ Social Security Disability Insurance	$
____ Supplemental Security Income	$
____ Workers Compensation	$
____ Public Assistance (Specify) _______________	$
____ Veterans Benefits	$
____ Spousal Income	$
____ Other (Specify) ____________________________	$
(D) Total Annual Gross Income (add all sources of income listed above)	$
(E) Allowable Deductions	
____ Monthly Medical Expenses	$

____ **I have attached verification of the above income amounts.**
____ **I have attached verification of monthly medical expenses. (health insurance premiums, medical supplies and/or equipment, prescription costs)**

SECTION 9: DEPENDENT INFORMATION

Total Number of Persons Dependent on the Above Income (D) _______
Specify Number (check all that apply):
____ Spouse ____ Number of Dependent Children
____ Parent(s) ____ Other (Specify Relationship)__________________

NAME OF APPLICANT: ____________________________________DATE OF APPLICATION: _______

SECTION 10: MY REQUIRED ORIGINAL SIGNATURES

I understand that I must submit original signatures on my application for the Attendant Care Program. This means that the Attendant Care Program will not accept any photocopies or faxes of my application.

I further understand that if a designee or authorized representative is completing and signing my application, I must include, with the application, a notarized letter of consent, court papers, or a Power of Attorney authorizing my designee or representative to apply on my behalf.

I hereby certify and attest under the penalties of perjury that the information contained in this application is true and correct to the best of my knowledge and that, if I am approved for participation in the program, I will immediately report any changes in this information to the Attendant Care Program.

_______________________________________ ____________________

Applicant's Original Signature Date

SECTION 11: FINANCIAL INFORMATION

I hereby certify that the income information I have supplied to the Attendant Care Program is true and correct to the best of my knowledge. I agree that, if I am approved for participation in the program, I will immediately report any change in my income to the Attendant Care Program. I further certify that I am not receiving reimbursement from any other program or agency for paying my attendant care costs.

_______________________________________ ____________________

Applicant's Original Signature Date

SECTION 12: RELEASE OF INFORMATION

I hereby authorize the Maryland Department of Disabilities Attendant Care Program to verify information regarding my application and authorize my employer, prospective employer(s), physician's office, financial institutions, or other individuals to release information and/or documents to the Maryland Department of Disabilities to establish my eligibility.

_______________________________________ ____________________

Applicant's Original Signature Date

FOR OFFICE USE ONLY:

Reviewed By	Date Rec'd:	Date Processed:	Disposition: App Pend Den Cl WL	Pending Information:
Enrollment Date:		Denied/Closed Date:	Waiting List Date:	

NAME OF APPLICANT: ___________________________________DATE OF APPLICATION: _______

Authorization for Release of Records and Information

A. Identification. Please PRINT in this section. This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Name: ____ Date of Birth: ________________

Address: ____

Social Security Number: ___________________ Daytime Phone Number: _______________

B. Directions for Release. I understand that the information to be disclosed and/or used is protected health information about me including, without limitation, medical records, diagnoses, assessments of capability, claims records, claims status, and patient management records. I authorize the disclosure and/or use of protected health information about me in order to confirm my eligibility for participation in the Attendant Care Program. I authorize the disclosure and/and or use of protected health information about me <u>to</u> the Maryland Department of Disabilities <u>from</u> the health care provider who has signed the enclosed Patient Health Evaluation and Standard Assessment of Functional Capability Form **AND** from the following (please print):

Heath Care Facility: ____

Physician/Provider (Name): ____

C. Right to Revoke. I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. To revoke the Authorization, I understand that I must contact the following in writing: Attendant Care Program, Maryland Department of Disabilities, 217 East Redwood Street, Suite 1300, Baltimore, Maryland 21201.

D. Authorization and Signature: I authorize the release of my confidential protected health information as described in Section B. This authorization is voluntary and I understand that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient (Department of Disabilities) unless the recipient is covered by Maryland law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. My treatment, payment, enrollment in a group health plan and eligibility for health care are not conditioned on signing this authorization.

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____________________________________ ____________________

Applicant's Original Signature Date

_____________________________________ ____________________

Original Signature of Witness Date

Authorization expires in 1 year, unless you designate an earlier date. Expiration: _____________

NAME OF APPLICANT: ________________________________DATE OF APPLICATION: _______

STANDARD ASSESSMENT OF FUNCTIONAL CAPABILITY
(TO BE COMPLETED AND SIGNED BY PHYSICIAN OR REGISTERED NURSE*)

The Maryland Department of Disabilities administers the Attendant Care Program. This program provides financial reimbursement for attendant care services to eligible individuals with disabilities. This Standard Assessment of Functional Capability is required for individual eligibility determination. Please complete this Standard Assessment of Functional Capability and return to:

Maryland Department of Disabilities
Attendant Care Program
217 East Redwood Street, Suite 1300
Baltimore, Maryland 21202

***All Pages of the Assessment must be completed and signed by the same Physician/Registered Nurse.**

APPLICANT/PATIENT INFORMATION

____ ______-______-_________
Name Social Security No.

_____/_____/_______ _______ (_____)_____-__________
Date of Birth Age Telephone Number

____
Street Address

____
City County State Zip Code

PATIENT HEALTH EVALUATION

Medical History (Statement regarding onset of disability, Diagnosis and Prognosis, and any communication limitation)

Diagnosis: ____
____
____
____

Does the Individual have: ____ Spinal Cord Injury ____Traumatic Brain Injury
Does the Individual have: ____ Low/Loss of Vision ____Low/Loss of Hearing

Date of Initial Visit __________________ **Date of Most Recent Visit** _________________

Original Signature of Physician or R.N.:________________________________ Date: _________

NAME OF APPLICANT: ________________________DATE OF APPLICATION: ________

ACTIVITIES OF DAILY LIVING (Circle Applicable Description)		
Client Eats	**Client Uses Toilet**	**Client Walks**
2 By self **1** With assistance **0** Must be fed / intravenously / tube fed	**2** By self **1** With assistance **0** Must have complete assistance	**2** By self **1** With assistance from another person **0** Must have complete assistance
Client Transfers to Bed or Chair	**Client Travels Beyond Walking Distance**	**Client Takes Medications**
2 By self (or with object) **1** With assistance from another person **0** Must be lifted **0** Bedbound	**2** By self (including public transportation) **1** Needs some assistance / escort **0** Must have complete assistance / specialized vehicle	**2** By self **1** Needs assistance / reminders **0** Must have complete assistance
Client Gets Dressed / Changes Clothes	**Client Prepares a Light Meal**	**Client Handles Own Money**
2 By self **1** With assistance **0** Must be dressed	**2** By self **1** With assistance for selected items **0** Must have complete assistance	**2** Writes checks by self, keeps track of funds **1** With assistance, e.g., checkbook, paying bills **0** Must have complete assistance
Client Completes Bathing	**Client Does Light Chores**	**Client Uses Telephone**
2 By self **1** With help washing, turning on water, etc **0** Must have bed bath / total assistance	**2** By self **1** With assistance; e.g., making a bed **0** Must have complete assistance	**2** By self **1** With assistance dialing / using directory **0** Cannot make and/or receive calls
Client Completes Grooming	**Client Does Grocery Shopping**	**Client Plans & Makes Decisions**
2 By self **1** With help shaving / combing hair **0** Must have complete assistance	**2** By self **1** With assistance/someone to go with **0** Must have complete assistance	**2** By self **1** With assistance **0** Dependent on others to plan / decide

Total ADL Score _________ (Add the numbers circled and enter as the Total ADL Score)

Original Signature of Physician or R.N.:___________________________________ Date: ___________

NAME OF APPLICANT: _________________________DATE OF APPLICATION: ________

ESTIMATED HOURLY NEED		
FUNCTION/TASK	**HOURS PER DAY**	**HOURS PER WEEK**
Assistance with Eating	_________	_________
Routine Bodily Functions (Bowel and Bladder Care)	_________	_________
Transfers (To and From Bed, Chair, Wheelchair, Automobile)	_________	_________
Personal Hygiene (Bathing, Dressing, Grooming)	_________	_________
Household Chores (Laundry, Meal Preparation, Cleaning, Transportation, Grocery Shopping)	_________	_________
Total Hours	_________	_________

SPECIFY ANY ADDITIONAL NEEDS OR COMMENTS

____

____

____

____

PHYSICIAN'S CERTIFICATION

I certify, based on the above Standard Assessment of Functional Capability, that the above named individual has a chronic or permanent disability that precludes or significantly impairs the individual's independent performance of essential activities of daily living, self-care, and mobility.

_______________________________________ _______________________

Original Signature of Physician or R.N. Date

Please Print or Type:

_______________________________________ (_____)______-_________

Name of Physician or R.N. Office Telephone Number

____

Address City State Zip

Please indicate professional designation and/or specialty:

____

NAME OF APPLICANT: _________________________DATE OF APPLICATION: ________