DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Application for Physical Disabilities Services

Part A - To be Completed by the Applicant

Applicant's Personal Information

Name:	Date of Birth: Over 18: Δ Yes Δ No		
Address:	City:	State:	Zip:
Social Security #:	Home Phone: ( ) - Cell Phone: ( ) -	Work Phone: ( ) - e-mail:	
Present living situation: Δ House Δ Apartment Δ Nursing home Δ Other (explain):			
Description of Disability: In order to qualify for Physical Disabilities Services, you must have a physical impairment that has resulted in the functional loss of two or more limbs. Please describe the nature of your disability:			
Is this condition: ΔTemporary ΔPermanent	Date of onset:		
If your disability is temporary, what is the expected duration of the disability?:			
Do you have a Medicaid Card? ΔYes ΔNo ΔPending	What is your gross monthly income? $		
Do you currently receive home health aide services? ΔYes ΔNo If yes, how many visits?____/day or____/week Do you currently have a personal attendant <u>not from a home health agency</u>? ΔYes ΔNo If yes, how many hours?____/day or____/week What is the name of your personal attendant (if you indicated that you have one)? _____			

Please indicate the activities of daily living you require assistance with (check all that apply):

☐ **Dressing**	☐ **Grooming**	☐ **Cooking**
☐ **Eating**	☐ **Laundry**	☐ **Grocery Shopping**

☐ **Assistance/Support to Transfer to or from a Bath/Shower or a Transportation Vehicle**

☐ **Assistance with Tasks/Services such as Ventilator, Catheter Care, Suctioning or Overnight Attention**

Please describe your expectations of how this program will help you:

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Application for Physical Disabilities Services

Part A (Continued) - To be Completed by the Applicant

Applicant's Verification

Dear applicant: Physical Disabilities Services may only be delivered through the self-administration method. This method supports an individual with a disability in self-directing the personal assistance services they receive through the Physical Disabilities program.

This means that you need to be aware that:

a) You are the employer, taking responsibility for hiring and managing your own personal attendants which includes responsibility for employee selection, scheduling, termination, performance evaluations, arranging back-up coverage, and submitting time sheets. Consumer Preparation Service, a preparatory service providing instructions for these tasks, is available through your Nurse Coordinator.

b) You must be able to instruct your personal attendants on many levels including how and when you need assistance, changing levels in personal needs, grievance procedures, emergency coverage, exploitation, and abuse.

This application is intended to point out any issues of concern or deficits that may prevent you from operating the program safely and efficiently.

I certify that the information provided in this application is true and accurate. I also agree to comply with all program requirements.

Applicant's Signature:	**Date:**
Comments:_____	
_____	
_____	

Return Completed Form to:
Division of Services for People with Disabilities
Attn: Nurse Coordinator
195 North 1950 West
Salt Lake City, UT 84116

FOR DIVISION OFFICE STAFF ONLY
STAMP DATE RECEIVED IN BOX

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Application for Physical Disabilities Services

Part B - To be Completed by the Physician

Physician's Name:	Phone:		
Address:	City:	State:	Zip:

Physician's Recommendations

SECTION I: DIAGNOSTIC INFORMATION

Dear Physician: Your patient is applying for Physical Disabilities Services through the Division of Services for People with Disabilities (DSPD). Physical Disabilities Services means hands-on care, of both a medical (to the extent permitted by State law) and non-medical services of a supportive nature, specific to the needs of an adult with a physical disability (assistance with activities of daily living and personal care). Please take a few minutes to complete this page. The information you provide will assist the DSPD Nurse Coordinator in making a determination of whether your patient is eligible for service.

Name of patient:

Patient's diagnosis:

ICD 10 Code:_____ **Definition:**_____

In order to qualify for Physical Disabilities services, the applicant must meet all of the following criteria. Please mark yes or no to each of these statements based on your professional judgment.

ΔYes ΔNo **Patient is medically stable.**

If No, please explain:

ΔYes ΔNo **Patient has a functional loss of two or more limbs.**

If No, please explain:

ΔYes ΔNo **Applicant's functional loss of two or more limbs is permanent.**

If No, please answer the next question below.

ΔYes ΔNo **Applicant's functional loss of two or more limbs is expected to last at least 12 months or more.**

If No, please explain:

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Application for Physical Disabilities Services

Part B (Continued) - To be Completed by the Physician

SECTION II: SELF-ADMINISTERED ASSESSMENT

Note to Physician: Self-administration is a service delivery method that supports an individual with a disability in self-directing the personal assistance services they receive through the Physical Disabilities program. Physical Disabilities Services may only be delivered through the self-administration method.

This means that in order to be eligible for Physical Disabilities Services, your patient must be able to:

a) Direct certain aspects of the patient's care. For example, they must have the ability to hire, train and supervise their own personal attendant(s) and determine how and when services are provided; and
b) Self-administer, which means being aware of his/her needs and having the ability to instruct the personal attendant as to how and when assistance is needed.

If you have concerns about your patient's ability to complete these tasks, please state them in the "Comments" section below. This assessment is intended to determine any issues of concern or deficits that may interfere with the patient's ability to self-direct the Physical Disabilities Services needed. Feel free to engage your patient in an open dialogue while going through parts (a) and (b) directly above.

I certify that the patient, based on the assessment above:

☐ **Is able to self-administer his/her program.**

☐ **Is not able to self-administer his/her program.**

Comments: _____

_____

_____

I certify that the information I have provided under sections I and II in this application is true and accurate to the best of my knowledge.

Physician's Signature:	**Date:**

Additional Comments: _____

_____

_____

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Attn: Nurse Coordinator
195 North 1950 West
Salt Lake City, Utah 84116

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