N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING SERVICES

INDEPENDENT LIVING SERVICES PROGRAM APPLICATION

A. Client Identifying Information

1. Social Security Number	2. Client Name, Last	3. First	MI

3. Date of Birth	4. Co.	5. VS

6. Application Date	7. Referral Source	8. Client Status	9. Status Date

10. Worker No.	11. Elg. Cat.	12. Goal	13. In-Home Aide Elg.	14. Reason

B. Service Plan and Action Taken

15. Service	16. Service Code	17. Approved	18. Denied	19. Modified	20. Terminated	21. Reason	22. Effective Date

C. In-Home Aide Services
Level I-- Home Management

23. Review Date

Income Type	Income Amount		No. In Income Unit
_____	_____	Per _____	
_____	_____	Per _____	

D. Explanation of Action (Citation: ILS Manual: Section ____ page ____)

If you disagree with any action checked above or if you think the information used to make the decision was incorrect, you have the right to ask for a conference. Instructions on the back on the form will tell you how to ask for a conference. I agree to abide by the Code of Conduct which states: In order to maintain a safe and supportive environment please note the following requirements: no weapons, no threats, no aggressive behavior verbal or physical, no harassment, and no property damage. By signing below, you are saying that you agree to the above statement and have given correct and complete information.

_____
Application Date

_____
Client (Parent/ Guardian)

_____
Social Worker for the Blind

_____
Witness (if needed)

_____
Date

TO:

This form is being sent to notify you of action taken regarding the request/ receipt of Independent Living Services. The action being taken is outlined in Section B and D of this form. This form also serves as your record of the information provided by you and used in determining eligibility for services. Your signature is Section D of the form certifies that you have been made aware of and agree to the rights and responsibilities contained in the following statement. Do not return this letter. Keep it for your records.

APPLICATION STATEMENT

I understand that for In-Home Aide Services: Level I-Home Management, I am responsible for providing Division of Services for the Blind income information necessary to determine eligibility for the service. Information provided by me is reflected on this form and represents a true and complete statement of the facts according to my best knowledge. I understand that it is against the law for me to make false statements or to withhold information affecting eligibility and that I am subject to prosecution if I do. I also understand that the information provided by me may be subject to verification and that I may be asked (at this time or at a later date) to provide documentation which supports the information I provide. I agree to notify the agency within five days of any change in address, employment, income, living arrangements, or family size.

I understand that the information I provide will be held in strict confidence and will not be revealed to anyone without my written consent except for information necessary to authorize the provision of service and establish eligibility, and information that may be revealed in the course of agency audits and monitoring. I hereby give consent for release of information by the Social Security Administration needed to determine eligibility for services.

I also certify that I am not being forced or requested to accept a service against my wishes.

I understand that I have a right to request and obtain a conference if the agency does not act upon my request with reasonable promptness (i.e., within 30 days of the date services are requested) and/or if I disagree with agency's action in response to my request. If eligible, I understand that services will be provided or arranged within 15 days of notification, if such services are available.

HOW TO GET A CONFERENCE

If you wish to request a conference, you must contact the Division of Services for the Blind within sixty (60) days after this letter was mailed. A conference will be scheduled for you with an official of the Division of Services for the Blind. If you are dissatisfied with the decision made at the conference, you may have a hearing with the official from the Office of Administrative Hearings.

At either of these conferences,/hearings, you may have someone such as a relative or friend represent you. You may have an attorney represent you but you must pay for his services yourself, unless free legal services are available in your community. If you are interested in free legal service, contact your worker.

If your request for services was denied and you wish to request a conference, you must contact the Social Worker for the Blind within sixty (60) days after this letter was sent. If your services were terminated or modified and you wish to request a conference, you must contact the Social Worker for the Blind within (60) days after the effective days entered in Section B on the front of this letter.

If your services were terminated or modified for any reason other than lack of public funds to pay for them, you may keep receiving your services until the local conference decision if you ask for a conference on or before the date entered in Section B on the front of this letter. However, if your conference shows that the decision was correct, you may have to repay the cost of the services received while waiting for the conference. If you do not wish to continue to receive the services as before, you may ask your worker to stop them.