CONSUMER APPLICATION

ADVANCED DIRECTIVE - APPLICATION FOR ASSISTANCE

Based on non-profit directives qualifying consumers must be defined as "at risk senior" which may require an accompanying physician affidavit of need if less than 85 years of age. Consumers over 85 years of age may qualify if hospitalized within the past year and or show a high risk of hospitalization based on diagnoses and physician affidavit or hospitalization risk within the next year. Applicants under 65 must show physician affidavit supporting disability status and at risk status. Those consumers considered for funding within that category will not be included in aggregate study data.

Name_____

Phone_____ DOB_____Age_____

Mailing Address _____

Currently residing at (i.e. if hospitalized, confined to nursing home, etc.)_____

Support Being Requested (choose):

- Healthcare Proxy and/or Fiduciary - Case Management Support (check one):
  - ❑ I desire to maintain my independence at home and request advocacy to maintain community independence. Should I be hospitalized I would like an advocate to assist me back into community living avoiding unnecessary confinement to long term care .
  - ❑ I am currently in a nursing home or hospital looking to assign an advocate for transitional planning to assist me back into community living or a lesser level of care.

You attest you do not have available family to assist adequately and require grant assistance. Please note below in comments why need this assistance (i.e., have family but not locally, disabled themselves, etc.).

- Requesting assistance with (check all that apply):
  - ❑ Medicaid application assistance to maintain residency at nursing home if required.
  - ❑ Require Medicaid Waiver to find more independent placement either in community or lesser level of care institution.

If applying for block grant for Medicaid Waiver assistance please note below in comments why you require grant assistance. (i.e., there is no onsite Social Worker able to represent you through this process or other means of advocacy, if hospitalized the waiting list through PATHWAYS or other acute care contracted assistance does not meet sense of urgency.)

COMMENTS: (attach any additional comments or supplemental to support your request) _____

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I attest that I am cognitively able to make an assignment for healthcare and or fiduciary POA to assist me in this request and not having been deemed incompetent by chancery court to do so.

Signature_____ Date _____