Ron Yost Personal Assistance Services ■ PO Box 625 ■ Institute, WV 25112-0625
1-855-855-9743 ■ (304) 766-4624 ■ FAX (304) 766-4721

Thank you for your interest in the Ron Yost Personal Assistance Services (RYPAS) program. Enclosed is a brochure explaining the intent and history of RYPAS.

If you are interested in applying for services, please complete and return the enclosed Application form, Financial Survey form, and Short Assessment form. Once the application packet has been received, it will be reviewed by the RYPAS Board at their next monthly meeting, and you will be notified of their determination. Please be advised that there is a waiting list for RYPAS services. However, prompt compliance with providing the requested documentation will expedite your application.

In accordance with state law, all RYPAS applicants are required to apply for personal assistance services they may be eligible for through Medicaid programs. **Therefore, you need to do the following:**

1. **Apply for the Aged and Disabled Waiver program –** to initiate this application process, you should have your physician complete the enclosed form and mail or fax it to the address or fax number on the form.
2. **Apply for Medicaid –** at your local Department of Health and Human Resources Office – and if eligible, go to # 3.
3. **Apply for the Personal Care Option under Medicaid –** by contacting your local Senior Center (even if you are under age 55). If you have a Medicaid card, apply for the personal care option only.

Should you decide not to accept the Medicaid services for which you are eligible, you will forfeit your eligibility for RYPAS and therefore be disqualified from receiving RYPAS services.

Once you have completed these application processes, please send:
(1) copies of your applications;
(2) denial letters for these services; and
(3) any letters you may have received confirming your placement on the A/D Waiver waiting list or otherwise verifying your eligibility for services

If you have any questions about the program or the forms, please call Jerry Boyko or Ann McDaniel at (304)766-4624 or 1-855-855-9743.

Sincerely,

The RYPAS Administrative Board

Reimbursement Rate Schedule

Income Reimbursement Category	Adjusted Annual Income	Reimbursement Percentage
1	$0 - 21,999	100
2	22,000 - 22,999	98
3	23,000 - 23,999	96
4	24,000 - 24,999	94
5	25,000 - 25,999	92
6	26,000 - 26,999	90
7	27,000 - 27,999	88
8	28,000 - 28,999	85
9	29,000 - 29,999	81
10	30,000 - 30,999	76
11	31,000 - 31,999	70
12	32,000 - 32,999	63
13	33,000 - 33,999	55
14	34,000 - 34,999	46
15	35,000 - 35,999	36
16	36,000 - 36,999	25
17	37,000 - 37,999	13
18	38,000+	00

RYPAS RECIPIENT EMPLOYER RESPONSIBILITIES

Household Employer

If you choose to hire your own personal assistants, they are considered household employees and you will have the following employer and tax responsibilities:

- Register with the federal & state governments
- Have each employee fill out the I-9 and the W-4
- Pay federal and state unemployment tax. If you pay an employee more than $1,000 per quarter or $4,000 per year then you are required to pay unemployment taxes.
- If you pay an employee more than $1,700 a year, you must decide whether to withhold federal income tax, Social Security tax and Medicare tax. It is not mandatory to withhold, but the taxes will have to be paid at the end of the year. Social Security is 12.4 percent of the wages you pay the employee. You have to pay 6.2 percent and the employee has to pay 6.2 percent. Medicare tax is 2.9 percent of the wages paid, 1.45 percent paid by you and 1.45 percent paid by your employee.
- Submit copies of your WV business certificate (or application), W-2 for your personal assistant(s), Schedule H and quarterly unemployment compensation reports

* Household employers do not have to pay Social Security, Medicare or FUTA taxes for wages paid to a spouse, a child under 21 years old, a parent, or any other employee under 18 years old.

Purchase Services through a Provider

You may choose to purchase your services through a provider. The cost to purchase services may be more than your reimbursement rate; however, you will not have employer responsibilities.

RON YOST PERSONAL ASSISTANCE SERVICES APPLICATION

Name: _____
Last First M.I.

DOB: _____ **Age:** _____

Home Phone: (___)_____ **Cell Phone:** (___)_____

E-mail Address: _____

Address: _____
Street / P. O. Box

_____
City County State Zip Code

Current Residence: ☐Own Home ☐With Family ☐Nursing Home

☐Other (please specify)_____

Other Contact Person: _____
Name

Parent/Guardian? _____ Yes _____ No

Contact Information (if different than above)

Address: _____
Street / P. O. Box

_____
City State Zip Code

Home Phone: (___)_____ **Cell Phone:** (___)_____

What is your disability? _____

Are you currently receiving personal assistance services from another organization/agency? _____Yes _____ No

If yes, please identify: _____

What would happen to your living situation if you are not approved for RYPAS?

_____

_____

☐ I have been informed of other programs that provide personal assistance, for which I may be eligible (Medicaid Aged and Disabled Waiver, and Medicaid Personal Care). **I will apply for them and, should I become eligible and start receiving said services, will inform the Ron Yost Personal Assistance Services Board immediately.**

**Should you decide not to accept the Medicaid services for which you are eligible, you will forfeit your eligibility for RYPAS and therefore be disqualified.*

☐ I will self-manage the financial responsibilities of my RYPAS services

OR

☐ I have appointed _____ to be my financial manager.
*I understand that this person may **not** and verify they **will not** provide me personal assistance services through this program.*

Note: The omission of any of the above information may delay determination of eligibility for services.

Please indicate your agreement with the following and mark corresponding boxes before signing this form:

☐ *I certify that the above information is true and correct, and understand that providing false information on this application is illegal.*

☐ *I hereby authorize the RYPAS Board to release this information to a Board approved provider for the purpose of obtaining a full functional assessment of my needs.*

☐ **My signature below certifies my authorization of a "Release of/for Information" to RYPAS staff for the sole purpose of communicating with Medicaid, or their representatives (i.e. APS Health Care) for the purpose of clarifying and expediting my application.**

_____ _____
Applicant's Signature Date

_____ _____
(If Applicable) Signature of Parent/Guardian/Power of Attorney Date

Submit to: RYPAS, c/o WVSILC, PO Box 625, Institute, WV 25112-0625
or fax to 304-766-4721

If you have any questions or need assistance, please call 304-766-4624
or 1-855-855-9743

FINANCIAL SURVEY: RON YOST PERSONAL ASSISTANCE SERVICES

Name: _____

	Monthly Income	ANNUAL INCOME
Wages (salaries, tips, commissions, fees)	$_____	x 12 = $_____
Workers' Compensation	$_____	x 12 = $_____
Unemployment Compensation	$_____	x 12 = $_____
Retirement/Pension	$_____	x 12 = $_____
SSDI	$_____	x 12 = $_____
SSI	$_____	x 12 = $_____
Alimony	$_____	x 12 = $_____
Other (specify)	$_____	x 12 = $_____
TOTAL INCOME		A. $_____

	Monthly Deductions	ANNUAL DEDUCTIONS
*Dependents		$_____
(1^{st} $3,000, 2^{nd} $2,000, and $1,000 for each dependent thereafter annually)		
Medication	$_____	x 12 = $_____
Medical Supplies	$_____	x 12 = $_____
Adaptive Clothing	$_____	x 12 = $_____
**Disability Related Equipment and Expenses	$_____	x 12 = $_____
TOTAL DEDUCTIONS		B.$_____

Total annual income minus total annual deductions = A. _____ minus B. _____

ADJUSTED ANNUAL INCOME = $_____

*A family member with gross earned income exceeding $7,500 annually shall not be considered as being dependent upon the applicant.

** Expenses include insurance co-pays and out of pocket pay to personal assistants.

STATEMENT OF APPLICATION

I, the undersigned, do hereby apply for Personal Assistance Services and certify that all information I have given/shall give pursuant to this application is/shall be true, correct and complete to the best of my knowledge. I have received and reviewed the explanation provided thereon of the Personal Assistance Services program and of my responsibilities and rights, including the criteria of eligibility, the right to due process, the right to nondiscrimination, and confidentiality.

_____

Applicant's Signature Date

_____

(If Applicable) Signature of Parent/Guardian/Power of Attorney Date

Submit to: RYPAS, c/o WVSILC, PO Box 625, Institute, WV 25112-0625

Name: _____

Address: _____

_____

Phone Number: _____

RON YOST PERSONAL ASSISTANCE SERVICES SHORT ASSESSMENT

This short assessment tool is to be used to estimate the hours of service needed by individuals applying for services through the Ron Yost Personal Assistance Services Program (RYPAS).

This is NOT to be considered the functional assessment required by the program and does NOT constitute a full, accurate assessment of need.

The purpose of this short assessment is to estimate individual need and give the RYPAS Board an estimate of the hours of need and the funding required in order to meet the needs of the individuals on the RYPAS waiting list.

Once an individual is approved for services, and RYPAS funding is available, a full functional assessment will need to be completed prior to the RYPAS Board approving hours of service and a start date for services.

Use this form to estimate the hours of assistance an individual will need in each of the main categories. A list of tasks in each category is included to help the individual determine the estimated need for services.

Category of Activities	Types of Assistance Required	Who Currently Provides Assistance?	Estimated Hours Needed Per Week
1. GROOMING/HYGIENE/EATING Activities May Include: Shaving/Applying Makeup; Teeth Care; Hair Care; Wash Face; Beard/Mustache Care; Eating; Remembering when to do self-care			
2. MOBILITY/TRANSFERS/ BATHING/TOILETING Activities May Include: Transfers In/Out Bed; Transfers In/Out Vehicle; Pushing Wheelchair; Turning in Bed; Showering/Bathing; Bowel Care			
3. TRANSPORTATION Activities May Include Assistance With: Private Transportation; Public Transportation			
4. HOUSEKEEPING Activities May Include: Cleaning; Remembering Tasks to Do; Remembering When to Do Tasks; Laundry; Cooking; Planning Menus; Shopping			

Category of Activities	Types of Assistance Required	Who Currently Provides Assistance?	Estimated Hours Needed Per Week
5. CONSUMER ACTIVITIES Activities May Include: Budgeting; Bill Paying; Making Change; Banking; Shopping			
6. DRESSING/TOILETING Activities May Include: Dressing; Knowing What to Wear; Fastening Fasteners; Bladder Care			
7. SOCIAL and COMMUNICATION Activities May Include: Personal Data; General Communication			
8. PERSONAL MANAGEMENT Activities May Include: Getting up on Time; Managing Daily Schedule			
TOTAL ESTIMATED HOURS NEEDED PER WEEK: _____			

I verify that I have estimated my hours of assistance as detailed above. I understand that this assessment does not replace the required functional assessment, nor does it constitute an approved number of hours.

Please be advised that there is a waiting list for RYPAS services. However, prompt compliance with the provision of the requested documentation will expedite your application and the start of services.

_____

Applicant's Signature Date

_____

(If Applicable) Signature of Parent/Guardian/Power of Attorney Date

Submit to: RYPAS, c/o WVSILC, PO Box 625, Institute, WV 25112-0625