LOUISIANA
DEPARTMENT OF HEALTH
Aging and Adult Services

State Personal Assistance Services (SPAS)

Application

Name: (Last, First, MI)	Social Security Number: / /	Telephone Number: ( ) -

Home Address: ______________________________

City: ______________________ State: __LA__ Zip Code: __________

Mailing Address (If different from home address) ______________________________

City: ______________________ State: __LA__ Zip Code: __________

Date of Birth:	Age:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Race:

List each disability/diagnosis:

Describe your disability and how it interferes with your daily activities.

What service(s) are you requesting?

Assistance required for activities of daily living.

☐ Mobility in bed ☐ Transfers ☐ Administering Medications ☐ Meal Preparation

☐ Locomotion ☐ Dressing ☐ Shopping ☐ House work

☐ Eating ☐ Toileting ☐ Managing Finances ☐ Phone use

☐ Grooming ☐ Bathing ☐ Personal Hygiene ☐ Transportation

Are you Employed? ☐ Yes ☐ No

(check all that apply)

If Yes:

☐ Employed part-time ☐ Retired on disability

☐ Employed full-time

If No:

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Seeking Employment? ☐Yes ☐ No ☐ Full-Time ☐ Part-Time

Please check off all services you are currently receiving:

☐ SSI ☐ Medicaid ☐ NOW Waiver

☐ SSDI ☐ Medicare ☐ Supports Waiver

☐ Veteran's Benefits ☐ Private Medical Insurance ☐ Long Term Personal Care Services

☐ Vocational Rehabilitation Services ☐ EDA Waiver ☐ ADHC Waiver

☐ Private Disability Insurance Benefits ☐ Traumatic Head and Spinal Cord Injury Trust Fund

List other persons living in your household: (Continue on back if more than 4)

Name	Age	Relationship	Describe any disabilities (if applicable)

Name two (2) people who do not live with you and who will know your address if you move:

Name	Address	Telephone Number

<u>Please Note</u> if your address or phone number changes before we contact you and you fail to notify us, every reasonable attempt will be made to contact you. If we cannot contact you, your name will be skipped and the next person on the waiting list will be contacted. I understand this statement.

Signature ______________________________

I hereby apply for services through the State Personal Assistance Services (SPAS). **I will voluntarily provide information relative to my disability/injury/accident and resources available to me.** Refusal to provide such information could affect my eligibility for services. I understand that such information will be held confidential and will be used only insofar as it affects my eligibility for the program and the delivery of services. Information will be released only with my authority and written consent or as otherwise authorized by the policy of the SPAS Program.

I understand that eligibility decisions will be made without regard to sex, race, creed, color or national origin. I further understand that eligibility decisions will be made without regard to disability unless, and only to the extent necessary, authorized by law to comply with Louisiana Legislature.

I certify that the information I have given is true, correct and complete to the best of my knowledge and that knowingly providing false or incorrect information is cause for immediate termination of benefits. I agree to notify the Arc of Louisiana or the program office within 30 days if I have a change in my financial condition or my physical/mailing

address(es). I understand that if I knowingly provide information which is incorrect, I may be required to reimburse, in whole or in part, the SPAS Program for funds provided to pay for the cost of certain services I have received.

DO NOT SIGN UNLESS YOU FULLY UNDERSTAND THE ABOVE THREE PARAGRAPHS

____ ________________________

Signature of Applicant Date of Application