Access Alaska Inc. Information and Referral Form

Access Alaska Inc. is a Center for Independent Living (CIL). Centers for Independent Living promote the full inclusion of people experiencing a disability into their community and society. The goals of a CIL are to teach the skills of independent living, with a primary focus on self-advocacy and consumer choice. We do not do what you can do for yourself; we support you in meeting your challenges and removing the barriers to being independent and successful in meeting your goals.

This form is the first step in establishing eligibility for Access Alaska Inc. and should be filled out by or alongside the person seeking services or their legal representative.

Today's Date: _____ **Name of Person Seeking Services**: _____
Date of Birth: _____ **Phone**: (____)_____ ☐ Cell ☐ Landline ☐ Other _____

Can we leave a voice message on this number? ☐ Y ☐ N **Can you receive text messages this number?** ☐ Y ☐ N

Email Address: _____ **What is the best way to reach you?** ☐Phone☐ Email ☐Text

Physical Address: _____

City/State/Zip: _____ **Mailing address the same?** ☐ Yes ☐ No

If no, Mailing Address: _____

Mailing City/State/Zip: _____ **Gender**: ☐ Male ☐ Female

Ethnicity: ☐ American/Alaska Native ☐ White ☐ Asian ☐ Hispanic/Latino ☐ Black/African American ☐Hawaiian/Pacific Islander ☐Prefer not to Answer

Primary Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Native Alaskan ☐ Other: _____

Legal Representative Name (If Applicable): _____

Representative Type: ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Legal Rep. Phone: (____)_____ **Legal Rep. Email**: _____

Do you experience a disability? ☐ Yes ☐ No **Disability Type** ☐ Physical ☐ Developmental Disability ☐ Cognitive ☐ Mental/Emotional ☐ Hearing ☐ Vision ☐ Other: _____

Please tell us about how your disability impacts you:

How did you hear about Access Alaska? ☐ Family/Friend ☐ Service Provider, Who? _____ ☐ Web search ☐ Access Alaska Staff ☐ Other: _____

What help are you seeking from Access Alaska Inc.? (Check all that apply): ☐ Self Advocacy Skills Training ☐ Assistance completing paperwork ☐ Finances/Benefits Assistance ☐ Accessing Medical Services ☐ Independent Living Skills ☐ Housing Search/Application ☐ Employment/Vocational Skills Development ☐ Nursing/Assisted Facility Transition ☐ Peer Support & Mentoring ☐ Transportation ☐ Personal Care Services*

**If you are interested in Personal Care Services, please fill out the 'PCS Additional Info' box on page 2*

What is your Income per Month? $ _____ **Where does your money come from? (Check all that apply)**:
☐ Adult Public Assistance ☐ ATAP ☐ SSI/SSDI ☐ Senior Benefit ☐ Retirement ☐ Native Benefit ☐ VA
☐ Food Stamps ☐ Other:

Do you receive Medicaid?	☐ Y ☐ N ☐ Applying
Do you receive Rental Assistance?	☐ Y ☐ N
Are you a US Veteran?	☐ Y ☐ N
Are you working with Division of Vocational Rehabilitation (DVR)?	☐ Y ☐ N
Are you a Registered Voter?	☐ Y ☐ N
If no, are you interested in registering to vote?	☐ Y ☐ N ☐ N/A

What is your employment status? ☐ Unemployed, not seeking employment ☐ Part-Time ☐ Full-Time
☐ Volunteer ☐ Unemployed, seeking employment ☐ Retired

What is your marital status? ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Other:

Is there anything else you would like us to know related to services you are seeking?

Please complete the information below if you are interested in Consumer Directed Personal Care Services:

Personal Care Services (PCS) Additional Info: ☐ **N/A**

Will you be using Medicaid to apply for PCA services? ☐ Y ☐ N Medicaid Number: _____
Private Pay? ☐ Y ☐ N If using insurance, will your carrier cover Custodial PCA services (not home health care)? ☐ Y ☐ N Do you have a Direct Support Professional? ☐ Y ☐ N Are they able to pass a background check? ☐ Y ☐ N Do they have a CPR/FA Certification? ☐ Y ☐ N
Are you new to PCS services or transferring from another agency? ☐ New ☐ Transferring
If transferring:
from where/why:
Are you transitioning out of a nursing facility or other institution? ☐ Y ☐ N
If yes,
what facility?
KIND OF ASSISTANCE NEEDED:
☐ Body Mobility (bed bound only) ☐ Transfers ☐ Locomotion ☐ Dressing ☐ Eating/Drinking ☐ Toilet use ☐ Personal Hygiene ☐ Bathing ☐ Meal Prep ☐ Housework ☐ Shopping ☐ Laundry ☐ Minor Respiratory Equipment Maintenance ☐ Medical Escort ☐ Medication Assist *Scripts required:* ☐Range of Motion

Primary Doctor: _____ **Clinic/Hospital**: _____
Contact #: (_____)_____

By submitting this form to Access Alaska Inc. you certify that all the information submitted in this form is true and accurate to the best of your knowledge.

For CIL Staff Use Only:

☐ I&R Information entered into CIL Suite / Staff Initial & Date: ____ | _____
☐ I&R Form scanned into Consumer CIL Suite Document Center / Staff Initial & Date: ____ | _____
☐ I&R reviewed by manager / Manager Initial & Date: ____ | _____
Assigned Staff, If Applicable: _____