

UTAH INDEPENDENT LIVING CENTER

Assistive Technology Program/Fact Sheet

The mission of the Utah Independent Living Center (UILC) is to assist persons with disabilities achieve greater independence by providing services and activities which enhance independent living skills and promote the public's understanding, accommodation and acceptance of their rights, needs and abilities.

UILC staff members provide individual peer support, classes, groups and other activities needed by individuals with disabilities to enhance their independence. Independent living services are also outreached into local high schools, the Community Center for the Deaf, care facilities, and individuals' homes. Community accessibility and advocacy activities also occur in order to allow people with disabilities to utilize community resources and participate in community events.

To be eligible for independent living services an individual must have a substantially significant physical or mental disability that impairs activities of daily living and a reasonable expectation must exist that services provided will be beneficial in the move toward increased independence.

Assistive technology services are an integral component in the array of services available at the UILC to assist an individual to be more independent at home and in the community. This program consists of non paid services such as peer support, community networking or coordinating resources and paid services which are the purchase of assistive equipment, evaluations, training, etc., needed by consumers to be more independent. The UILC Assistive Technology Service Coordinator works closely with each consumer to determine what assistive equipment best meets their needs, collects information and documentation necessary for equipment purchase and submits this information to the Utah State Office of Rehabilitation (USOR). The funding for equipment is generated from the USOR. Due to the nature of this program and because of this unique partnership for funding, the following definition, guidelines and procedures have been established for individuals receiving paid assistive technology services.

Assistive equipment can be broadly defined as any item, device or product that is used to address a functional limitation of a person with a disability to increase or maintain independence.

- 1) To receive Independent Living (IL), Assistive Technology (AT) paid services, meaning assistive equipment or devices, an individual must meet eligibility and income requirements. In the event the individual is a minor, the family must also meet income requirements.
- 2) At application, the individual or family will be asked to complete the Confidential Report of Financial Circumstances (form ILP-a).
- 3) Since the Independent Living Assistive Technology program deals with many consumers, it is the consumer's or family's responsibility to provide information necessary for service provision. If you move or change your telephone number, it is your responsibility to provide information necessary to contact us with changes.

- 4) Because of our limited budget, we are not always able to serve all applicants who apply for assistive equipment. If an applicant has other similar benefits such as Vocational Rehabilitation, Medicaid, Medicare, private insurance, etc., the applicant needs to apply to them first for the requested equipment. For a school age students who need an augmentative communication device, computer, or other equipment needed at school he/she needs to apply to his/her school first. If similar benefits can not purchase the equipment, we need a denial letter that will be placed in the consumer's file.
- 5) If similar benefits are not able to purchase assistive equipment needed and if the consumer meets the criteria for services of UILC, the file will be processed. Eligibility requirements are that the consumer is **significantly disabled** and he/she needs the equipment to be **independent in everyday living not employment**. Equipment purchased needs to be related to a specific **functional limitation** of each consumer. The UILC does not purchase therapeutic or recreational equipment, medical supplies nor farming equipment,. We do not do home modifications or permanent structures. We can not purchase vehicles.
- 6) Consumers will need an evaluation for most assistive equipment from a professional, such as a doctor, speech therapist, physical therapist, occupational therapist, etc. If necessary we can refer consumers to evaluators.
- 7) Consumers need to participate in choosing the right equipment to meet their needs. For example, if a ramp for a vehicle is needed the consumer with his/her wheelchair needs to be present for the evaluation.
- 8) Because of limited resources, eligible consumers may need to wait up to one year to get equipment. The length of waiting can be variable. Also, consumers will need to prioritize their equipment request. We are not always able to purchase all equipment.
- 9) After a consumer receives assistive equipment from the UILC, an equipment receipt will be sent to you for a signature. It is important to make sure you have received all your equipment and it is working before signing. It is the consumer's responsibility to contact the UILC Assistive Technology Service Coordinator if the equipment is not working. The equipment receipt needs to be mailed back to us. After three years, your file will be closed, but only after you have been notified. Ongoing repairs are the consumer's responsibility and will not be paid by this program.
- 10) Once your file has been closed if new assistive technology needs arise, you will need to reapply. If reapplying with three years of closure and your circumstances remain the same, only a financial sheet needs to be submitted with proof of income.

For more information contact:

**Address: Utah Independent Living Center
3445 South Main Street
Salt Lake City Utah 84115-4418**

**Telephone: 801-466-5565 (V/TTY)
Fax: 801-466-2363
E-mail uilc@xmission.com**

Outside of Salt Lake County: 1-800-355-2195

**INDEPENDENT LIVING PROGRAM
APPLICATION**

1. Social Security Number _____
2. Name _____ Male Female Age _____
Address _____ Date of Birth _____
(Street) _____
Phone () _____
(City) (State) (County) (Zip Code)
3. White African Amer. Amer. Indian Asian/Pacific Islander Hispanic
4. Marital Status: Never Married Married Divorced Widowed Separated Number of Dependents _____
5. Who referred you to this program? _____
6. What is your disability (ies)? _____
What caused your disability (ies)? _____
In what way does your disability limit your independence? _____

7. Are you currently receiving a cash benefit from SSDI? Not an applicant currently allowed benefits
Denied benefits Application is pending benefits have been discontinued Amount Received \$ _____
8. Are you currently receiving a cash benefit from SSI? Not an applicant currently allowed benefits
Denied benefits Application is pending benefits have been discontinued Amount Received \$ _____
9. Have you been in the military? Yes No Are you eligible for veteran's benefits? Yes No
10. What is your educational level? _____ Have you ever had an IEP? Yes No
Are you presently attending school? Yes No
If yes, name of school _____
11. What are your living arrangements? _____
12. Are you currently or have you received Vocational Rehabilitation Services? Yes No
13. Have you previously received services through a Center for Independent Living? Yes No
14. Are you presently working? Yes No How many hours per week? _____

15. Do you have services available to you from? (Check all that apply)

- Medicare [] Medicaid [] Other medical insurance []
- Easter Seals [] Muscular Dystrophy [] Shriners []
- United Cerebral Palsy [] Fraternal Organizations [] Religious org. []
- Family and Friends [] Private Insurance [] Vocational Rehabilitation []
- Veterans Administration [] M.S. Society [] Other (specify) [] _____

What is the primary source of your income at this time? _____

16. Do you receive: TANF Yes [] No [] Amount \$ _____ General Assistance Yes [] No [] Amount \$ _____

Other Public Support Yes [] No [] Amount \$ _____

17. Write a statement of your needs and how you feel the Independent Living Program can help.

The information contained in this form is true and correct to be the best of my knowledge. Permission is granted to the Independent Living Program to make whatever inquiries might be necessary to verify these statements. In applying for independent living program services, I understand there is a need to collect personal information.

I understand that consumer service record information is necessary to determine eligibility and, therefore, mandatory. Failure to provide requested information may result in a determination of not being eligible for Independent Living Services.

I understand that consumer service record information concerning me will be kept confidential.

I understand that I have the opportunity for a timely review of any dissatisfaction with a determination made by my Independent Living Coordinator concerning the furnishing or denial of Independent Living Services by contacting:

I understand that a Client Assistance Program Representative is available to act as my advisor and advocate, and that I may call toll free 1-800-662-9080 or Salt Lake 363-1347 to reach the Disability Law Center / Client Assistance Program (CAP), 205 North 400 West, Salt Lake City, UT 84103.

I understand that services in this program are provided without regard to sex, race, age, religion, color, or national origin according to Title VI of the Civil Rights Act, and Section 504, Rehab Act of 1973, as amended. The Independent Living Program also assures that no group of individuals will be excluded or found ineligible on the basis of type of disability.

Date

Consumer/Guardian/Representative Signature

Would you like to register to vote? Yes [] No [] (This information will not affect your eligibility.)

Please return this form to: UTAH INDEPENDENT LIVING CENTER, INC.
3445 S MAIN STREET
SALT LAKE CITY, UTAH 84115-4418

INFORMATION CONTAINED IN THIS APPLICATION WILL BE KEPT CONFIDENTIAL

IL-1a
06/07

INDEPENDENT LIVING PROGRAM
CONFIDENTIAL REPORT OF FINANCIAL CIRCUMSTANCES

In order for you and your IL Coordinator to determine financial need for the services outlined in your Independent Living Plan, the following financial information is required. (Note: Minors living with parent(s) must include the parent income. Married applicants must include the income of their spouse.) Tax forms, check stubs, retirement documents, and other forms of verification may be required.

Full Name / Social Security Number / Age

[] I choose not to complete the financial disclosure form. In doing so, I understand that I will **not** be eligible to receive paid Independent Living assistive technology services.

Family Size _____ Include all household members included as dependents on federal tax forms.
(If you don't file federal taxes, include all household members who could be included as dependents if you did file.)

Number of dependents 18 years or older _____
Number of minor dependents _____

- | | | |
|---------------------------------------------------------------|---------------------------------------------|----------|
| 1. Monthly Supplemental Security Income (SSI) \$ _____ | 4. Additional Monthly Income | |
| | Alimony and Child Support | \$ _____ |
| 2. Monthly Gross Earned Income | Veterans Pension | \$ _____ |
| Your own \$ _____ | Interest or Dividend Income | \$ _____ |
| Parent(s) (if a minor) \$ _____ | Social Security Retirement | \$ _____ |
| Income of spouse \$ _____ | Workers Compensation | \$ _____ |
| Total Monthly Earned Income \$ _____ | Social Security Disability Insurance (SSDI) | \$ _____ |
| 3. Allowable Deductions from Monthly Earned Income | | |
| State and Federal Tax \$ _____ | Other Disability compensation | \$ _____ |
| FICA \$ _____ | Total Additional Monthly Income | \$ _____ |
| Retirement you pay \$ _____ | Add Adjusted Gross Monthly Inc. | \$ _____ |
| Adjusted Gross Monthly Income \$ _____ | 5. Total Monthly Non-exempt Income | \$ _____ |

6. Liquid Assets (include all liquid assets unless in a qualified retirement account)

Savings Account \$ _____
Other Liquid Assets \$ _____
Total Liquid Assets \$ _____

Do you anticipate any significant changes in your financial circumstances within the next year? Y / N

If yes, please list the source _____ Please list the **monthly** amount \$ _____

Allowable Monthly Expenses You Pay

Court ordered support payments i.e. alimony or child support for children **not** being counted as family members on the front of this form (fines, restitution, and other non-support payments are not allowed). \$ _____

Monthly medical and dental expenses which are **not** reimbursed \$ _____

Monthly health insurance premiums (your portion) \$ _____

Other *monthly* disability related expenses which are **not** reimbursed

Personal assistance services \$ _____

Disability related transportation expenses \$ _____

Repairs to prosthetic appliances, mobility aids, and adaptive equipment \$ _____

Monthly cost of therapy \$ _____

Monthly cost of any disability related service for spouse or dependent \$ _____

Other monthly disability related expenses not included above

_____ \$ _____

_____ \$ _____

7. Total *Monthly* Allowable Expenses **\$ _____**

I certify that the information contained in this form is true and correct to the best of my knowledge. Inaccurate or falsified information may be cause for denial of Independent Living paid services conditioned on financial need.

Signature of Consumer/Representative

Date