

Attachment D**Application for Attendant Care Services****Consumer Information**

Name of Consumer (Last, First, Middle)		Date	
Address (Street, Apt. No., City, State)		Zip Code	County
Telephone No.	Birth Date	Sex	Social Security Number

Disabilities	Date of Onset
	Date of Onset

Yes No Do you expect your physical disability(s) to last for a continuous period of not less than 12 months?

Yes No Are you capable of selecting, supervising, and if needed, firing an attendant?

Yes No Are you capable of managing or directing other to manage your own financial and legal affairs?

Yes No Do you require assistance to complete functions of daily living, self care, and mobility in the following:
(If yes, check all that apply)

Bowel, bladder or other bodily functions Grooming Transfers Meal Preparation Ambulation

Dressing Consumption of food Bathing None of the above

Other:

Yes No Are you currently receiving attendant care or other in-home services from another agency?
(If yes, specify)

Explain your need and reason for applying for attendant care services.

Provider Information

Name of Provider Agency	M.A. ID
Name of Provider Representative Completing this Form	Telephone No.
<input type="checkbox"/> Yes <input type="checkbox"/> No Is the consumer's name listed on a valid PA Access card?	

If yes, show PA Access card (information recipient number and card issue number) and enter zero (0) under weekly fee

Recipient Number

Card Issue Number

Family Composition

Name Last, First, M.I. (include applicant)	Relationship	Source of Income	Monthly Gross Income
Total Family Size »		Total Monthly Income »	
		Less Medical Expense Deduction »	
		Adjusted Monthly Income »	
		Weekly Fee »	

Medical Expense Deductions

Monthly Total: \$ _____

Affirmation of Information

I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete. I agree to report any changes in circumstances immediately to this service provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes. I understand that I have a right to request a department of public welfare fair hearing. This affirmation statement covers both sides of this form and all attachments required for the determination of eligibility under the attendant care program.

Signature of consumer