Consumer Intake & Establishing Eligibility

Date________ Consumer: ______________________________________ Birth Date: ____________

Telephone Numbers:___________________and/or_________________________County:____________

Physical Address: _________________________________Mailing Address:______________________
(Street) (Street)

_________________________________ ______________________
(City, State, Zip) (City, State, Zip)

E-mail Address:_____________________________ Race:____________ Gender: Male or Female

Marital Status: ____________ Registered Voter? YES or NO Veteran? YES or NO

Education Level: ____Program:______________________

Guardian? YES or NO If Yes, Name:___________________________ Relationship:_____________

Telephone Numbers:_______________________________and/or_________________________

SS#:_____________________ Medicaid:_____________________ Medicare #__________________

Monthly Income: ________________Do you have a Spenddown? ____ Yes/Amt $______ No _______

Has this Consumer relocated from a Nursing Home Facility back into the community? ______________

If no, has this Consumer continued to live in the community of his/her choice?_______________

*** This consumer is **eligible / ineligible** (circle one) for services from Access II, ILC because of*:

Please list the Consumer's disability(s) below:

Date Began	Disability Type	Specific Disability

Independent Living Plan

Goal Type	Set Date	Target Date	Completed	Description

Sign Here *ONLY* If I choose to *WAIVE* my Independent Living Plan: ________________________________

Alternate Contact **Name:** ______________________________**Relationship:**__________________

Address:____

Telephone: __________________________**Alternate Phone:**_______________

Establishing Eligibility

Check any that apply

- Currently Employed (16 + hours) Employer: ______________________________
- Hired to Begin Working Date: ______________________
- Seeking Employment
- In School At: ____________________________________
- Live Independently, Not Employed

Check all that apply

- Private Home
- Apartment
- Group Home
- Nursing Home
- Special Housing
- Live Alone
- Live with Attendant
- Live with Spouse and Children
- Live with Parents and Other Family
- Live with Other Adults

List names and relationships of adult family members who live with you:

____

Do you plan to change your living situation in the near future? Yes No
If Yes, please explain:____

Are you currently using Consumer Directed Services (CDS) ? Yes No
If yes, please explain:____

Are you currently receiving services through Department of Health & Senior Services (DHSS), or have you in the past? Yes No

VR Office____
Mental Health____
DHSS____
Other____

____
Staff Signature Date

____
Consumer / Guardian Signature Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

HOME AND COMMUNITY BASED SERVICES REFERRAL

DATE

PERSON BEING REFERRED (LAST, FIRST, MI)	DCN	RACE	SEX	DOB (MM/DD/YYYY)

PHYSICAL ADDRESS (STREET, CITY, ZIP)	MAILING ADDRESS (STREET, CITY, ZIP)	COUNTY	PRIMARY PHONE NUMBER	OTHER PHONE

MARITAL STATUS/LIVING ARRANGEMENTS	PRIMARY LANGUAGE	SPECIAL COMMUNICATION NEEDS

REPORTED HEALTH CONDITION

NAME OF PERSON MAKING REFERRAL	AGENCY NAME	PHONE NUMBER(S)

ADDRESS (STREET, CITY, ZIP)

OTHER PERSONS INVOLVED	ROLE	ADDRESS	PHONE
	Physician		
	Other Responsible Party		
	Other		

REASON FOR REFERRAL	☐ PERSONAL CARE ASSISTANCE (CONSUMER-DIRECTED MODEL) ☐ HOMEMAKER ☐ RESPITE CARE ☐ PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY ☐ ADULT DAY CARE ☐ HOME DELIVERED MEALS ☐ PERSONAL CARE ☐ ADVANCED PERSONAL CARE ☐ AUTHORIZED NURSE VISITS ☐ PERSONAL CARE RCF/ALF
SAFETY CONCERNS	☐ NO KNOWN CONCERNS ☐ DANGEROUS NEIGHBORHOOD ☐ ILLEGAL DRUG ACTIVITY ☐ CONTAGIOUS/ INFECTIOUS DISEASE ☐ STRUCTURALLY UNSAFE HOME OR ACCESS TO HOME ☐ WEAPONS IN THE HOME ☐ PEST INFESTATION ☐ HISTORY OF VIOLENT BEHAVIOR ☐ OTHER: EXPLAIN
MEDICAID STATUS	☐ ACTIVE ☐ SPENDDOWN (CHECKED CYBERACCESS WEBTOOL, MEDICAID CURRENTLY ACTIVE? – ☐ YES ☐ NO)

COMMENTS

DIRECTIONS TO PARTICIPANT ADDRESS

Authorization to Obtain Employment Numbers

I, ____, do hereby authorize a representative from Access II Independent Living Center, Inc to obtain my Federal Employer Identification Number, Missouri Identification Number, and my Division of Employment Security Number via the internet. I understand the importance of these numbers is so that I can legally be considered an Employer and pay an Attendant to provided services to me that has been authorized from the Missouri Department of Health and Senior Services for the Consumer Directed Services program.

____ ________________________

Consumer Signature Date

Note: Form SS-4 begins on the next page of this document.

Change to Domestic Employer Identification Number (EIN) Assignment by Toll-Free Phones

Beginning January 6, 2014, the IRS will refer all domestic EIN requests received by toll-free phones to the EIN Online Assistant. You can access the Assistant by going to www.irs.gov, entering “EIN” in the “Search” feature and following instructions for applying for an EIN online.

Attention
Limit of one (1) Employer Identification Number (EIN) Issuance per Business Day

Effective May 21, 2012, to ensure fair and equitable treatment for all taxpayers, the Internal Revenue Service (IRS) will limit Employer Identification Number (EIN) issuance to one per responsible party per day. For trusts, the limitation is applied to the grantor, owner, or trustor. For estates, the limitation is applied to the decedent (decedent estate) or the debtor (bankruptcy estate). This limitation is applicable to all requests for EINs whether online or by phone, fax or mail. We apologize for any inconvenience this may cause.

Change to Where to File Address and Fax-TIN Number

There is a change to the Instructions for Form SS-4 (Rev. January 2011). On page 2, under the "Where to File or Fax" table, the address and Fax- TIN number have changed. If you are applying for an Employer Identification Number (EIN), and you have no legal residence, principal place of business, or principal office or agency in any state or the District of Columbia, file or fax your application to:

Internal Revenue Service Center Attn: EIN
International Operation Cincinnati, OH
45999
Fax-*TIN*: 859-669-5987

This change will be included in the next revision of the Instructions for Form SS-4.

Form **SS-4** (Rev. December 2017) Department of the Treasury Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ Go to *www.irs.gov/FormSS4* for instructions and the latest information.

▶ See separate instructions for each line. ▶ Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ▶

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☑ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☐ Other (specify) ▶
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ Military/National Guard
- ☐ State/local government
- ☐ Farmers' cooperative
- ☐ Federal government
- ☐ REMIC
- ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

9b If a corporation, name the state or foreign country (if applicable) where incorporated | State | Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ▶
- ☑ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☐ Banking purpose (specify purpose) ▶
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Created a pension plan (specify type) ▶

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year December

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other
		4

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note:** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶

16 Check **one** box that best describes the principal activity of your business. ☑ Health care & social assistance ☐ Wholesale-agent/broker ☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Other (specify) ▶

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

Hire Personal Care Attendant

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☑ No

If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: Amber Wells c/o Access II Independent Living Center

Designee's telephone number (include area code): 660-663-2423

Address and ZIP code: 101 Industrial Parkway Gallatin MO 64640

Designee's fax number (include area code): 660-663-2517

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.

Name and title (type or print clearly) ▶

Applicant's telephone number (include area code)

Applicant's fax number (include area code) 660-663-2517

Signature ▶ Date ▶

Do I Need an EIN?

File Form SS-4 if the applicant entity does not already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
Started a new business	Does not currently have (nor expect to have) employees	Complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
Hired (or will hire) employees, including household employees	Does not already have an EIN	Complete lines 1, 2, 4a–6, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
Opened a bank account	Needs an EIN for banking purposes only	Complete lines 1–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Changed type of organization	Either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership)[2]	Complete lines 1–18 (as applicable).
Purchased a going business[3]	Does not already have an EIN	Complete lines 1–18 (as applicable).
Created a trust	The trust is other than a grantor trust or an IRA trust[4]	Complete lines 1–18 (as applicable).
Created a pension plan as a plan administrator[5]	Needs an EIN for reporting purposes	Complete lines 1, 3, 4a–5b, 9a, 10, and 18.
Is a foreign person needing an EIN to comply with IRS withholding regulations	Needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits[6]	Complete lines 1–5b, 7a–b (SSN or ITIN optional), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is administering an estate	Needs an EIN to report estate income on Form 1041	Complete lines 1–6, 9a, 10–12, 13–17 (if applicable), and 18.
Is a withholding agent for taxes on non-wage income paid to an alien (i.e., individual, corporation, or partnership, etc.)	Is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	Complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is a state or local agency	Serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581[7]	Complete lines 1, 2, 4a–5b, 9a, 10, and 18.
Is a single-member LLC (or similar single-member entity)	Needs an EIN to file Form 8832, Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes[8], or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business (Under Sections 6038A and 6038C of the Internal Revenue Code)	Complete lines 1–18 (as applicable).
Is an S corporation	Needs an EIN to file Form 2553, Election by a Small Business Corporation[9]	Complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity does not have employees.

[2] However, do not apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Do not use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that do not file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer* on page 4 of the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* on page 4 of the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously-assigned EIN.

Demographics / About Our Services

Date: ____________________ Consumer Name:____

DOB:____________________ Access II Staff:____

Disability:____ Ethnicity:___________________________

Address:____ City:_____________________________MO

Zip:_______________ County:______________________ Phone:________________________Gender:_____

Living Arrangements:_____________________________________Referral:______________________________

"X" each item as it is discussed with you. Initial any items you are interested in learning more about.

Intake Information

- Client Assistance Program (CAP) (Federally mandated)
- Consumer Directed Program Overview (IL Philosophy)
- Voter's Rights and Registration
- Organizational Information

Access II Independent Living Center, Inc Services

Five Core Services

- -Information and Referral
- -Advocacy
- -Peer Support
- -Transitions
- -Independent Living Skills Training

- Consumer Directed Services (CDS)
- Accessibility Services
- TAP- Telephone (Telecommunications Access Program)
- Benefits Counseling
- Circuit Breaker MO PTC
- Assistive Technology
- Equipment Loan Program
- Consumer Assistance Fund Request
- Nursing Home Transitioning
- Alternative Format
- Transportation
- disAbility Awareness Program
- IEP (Individualized Education Programs) Assistance
- Youth Services
- Universal Design Program
- Prescription Drug Assistance Program
- AgrAbility
- Low-Vision Equipment
- Food Pantry
- Other Services: ____

Please continue on other side…..

Skills I possess and am willing to teach and/or share with others…….

- ASL (American Sign Language)
- Computer
- Budgeting
- Shopping Comparison
- Cooking
- Cleaning
- Companionship
- Leadership
- Tutoring
- Lobbying
- disAbility Awareness
- Other… Please specify_______________

I am interested in volunteering at Access II. My area(s) of ability are…..

- Secretarial duties (copying, faxing, reception, etc)
- Newsletter Articles
- Read/Compile disability related newspaper clippings
- Office Organization
- Ramps and Home Modifications
- Recreation
- Provide Transportation
- Events Coordinator
- On-Site Consumer Assistance
- Advisory council to the Board of Directors
- Other… Please specify_______________

I have been offered information on Voter Registration: YES NO

I understand that Access II's 5 core services are provided to me at no charge and that I must qualify financially to participate in certain services that have been explained to me. I acknowledge that I have received information and a brochure on the Client Assistance Program (CAP).

_______________ _______________

Consumer Signature Date

_______________ _______________

Access II Staff Signature Date

Consumer Information Acknowledgement Form

I acknowledge that I have:

1) Received, reviewed, and understand information about rights available to me through Missouri's federally funded Client Assistance Program (CAP) and have been provided literature describing the program:

   Missouri Protection & Advocacy Services (MOPAS)
   Main Office: 925 South Country Club Drive
   Jefferson City, MO 65109
   Phone 573-893-3333 or 1-800-392-8667 Toll Free
   Fax 573-896-42312 or 1-800-735-2966 TDD

2) Received an orientation on the agency and an Access II Independent Living Center, Inc brochure;

3) Received an explanation of the purpose of an Independent Living Center (ILC) and have had an opportunity to discuss services offered by the Independent Living Specialist (ILS);

4) Met and/or spoken with the ILS who will be working with me as a guide and/or advocate, and we have discussed their professional relationship with me;

5) Expressed my expectations to the ILS and my expectations of the agency;

6) Been given an explanation of Access II-Independent Living Center, Inc's expectations of me;

7) Reviewed literature on "Authorization for Release and/or Request of Information" forms;

8) Received and discussed any financial arrangements needed for services related to my program;

9) Made an informed choice to either develop and Independent Living Plan (ILP) and pursuing a plan of action as described in the Independent Living Plan or signed an Independent Living Waiver;

10) I have access to Access II-Independent Living Center, Inc's grievance procedure in the event that I am dissatisfied with any action or inaction by Access II-Independent Living Center, Inc in connection with the provision of its services to me. Under the procedure:
    a) I first discuss my concerns with the Access II, Inc Certified Manager
    b) If I am dissatisfied, or it is impractical for me to discuss my dissatisfaction with the Certified Manager, I may submit a written grievance to Access II Independent Living Center, Inc Executive Director. The grievance is to be submitted within 10 working days after the action or inaction of the complaint
    c) If I am still dissatisfied, within 30 days after submitting the grievance to the Executive Director, I may submit a written grievance to the President of the Board of Directors for Access II Independent Living Center, Inc. The written decision of the Board of Directors about my grievance ends the grievance process.

11) Access II Independent Living Center, Inc is authorized and required to release statistical information concerning Access II's services to agencies, institutions, organizations, and others who fund, contribute, or otherwise support Access II's goals.

This information may also be included in Access II publications and/or other materials accessible to the public that Access II may publish;

12) Access II Independent Living Center, Inc is required by federal, state, and/or local laws to make its services available without discrimination based on race, gender (sex), religion, veteran status, disability, age, sexual orientation, and national origin.

☐ **I am an individual with a disability who:**

*has a physical, mental, cognitive or sensory impairment that substantially limits one or more of my major life activities;

*has a record of such an impairment; or

*is regarded as having such an impairment.

☐ **I am an individual with a significant disability** who has a severe physical, mental, cognitive or sensory impairment that substantially limits my ability to function independently in the family or community to obtain, maintain, or advance in employment.

____________________________________ ________________

Consumer / Guardian Signature Date

____________________________________ ________________

Access II Staff Signature Date