

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:

<u>Date Began</u>	<u>Disability Type</u>	<u>Specific Disability</u>
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Independent Living Plan

<u>Goal Type</u>	<u>Set Date</u>	<u>Target Date</u>	<u>Completed</u>	<u>Description</u>
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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)
- Hired to Begin Working
- Seeking Employment
- In School
- Live Independently, Not Employed

Employer: _____

Date: _____

At: _____

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/CCYY)
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PHYSICAL ADDRESS (STREET, CITY, ZIP)	MAILING ADDRESS (STREET, CITY, ZIP)	COUNTY	PRIMARY PHONE NUMBER	OTHER PHONE
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MARITAL STATUS/LIVING ARRANGEMENTS	PRIMARY LANGUAGE	SPECIAL COMMUNICATION NEEDS
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REPORTED HEALTH CONDITION		
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NAME OF PERSON MAKING REFERRAL	RELATIONSHIP	PHONE NUMBER(S)
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ADDRESS (STREET, CITY, ZIP)	
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OTHER PERSONS INVOLVED	ROLE	ADDRESS	PHONE
	Physician		
	Other Responsible Party		
	Other		

REASON FOR REFERRAL:

PERSONAL CARE
 ADVANCED PERSONAL CARE
 AUTHORIZED NURSE VISITS
 PERSONAL CARE RCF/ALF
 PERSONAL CARE ASSISTANCE (CONSUMER-DIRECTED MODEL)
 HOMEMAKER
 RESPITE CARE
 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
 ADULT DAY CARE
 HOME DELIVERED MEALS

MEDICAID STATUS	<input type="checkbox"/> ACTIVE <input type="checkbox"/> SPENDDOWN (CHECKED EMOMED, BENEFITS ARE IN EFFECT – <input type="checkbox"/> YES <input type="checkbox"/> NO)
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COMMENTS

DIRECTIONS TO LOCATE:

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.

Application for Employer Identification Number

OMB No. 1545-0003

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

EIN

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

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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
9a Type of entity (check only one box). Caution. If 8a is "Yes," see the instructions for the correct box to check.			
<input type="checkbox"/> Sole proprietor (SSN) _____		<input type="checkbox"/> Estate (SSN of decedent) _____	
<input type="checkbox"/> Partnership		<input type="checkbox"/> Plan administrator (TIN) _____	
<input type="checkbox"/> Corporation (enter form number to be filed) ▶ _____		<input type="checkbox"/> Trust (TIN of grantor) _____	
<input type="checkbox"/> Personal service corporation		<input type="checkbox"/> National Guard <input type="checkbox"/> State/local government	
<input type="checkbox"/> Church or church-controlled organization		<input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military	
<input type="checkbox"/> Other nonprofit organization (specify) ▶ _____		<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises	
<input type="checkbox"/> Other (specify) ▶ _____		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)			
<input type="checkbox"/> Started new business (specify type) ▶ _____		<input type="checkbox"/> Banking purpose (specify purpose) ▶ _____	
<input type="checkbox"/> Hired employees (Check the box and see line 13.)		<input type="checkbox"/> Changed type of organization (specify new type) ▶ _____	
<input type="checkbox"/> Compliance with IRS withholding regulations		<input type="checkbox"/> Purchased going business	
<input type="checkbox"/> Other (specify) ▶ _____		<input type="checkbox"/> Created a trust (specify type) ▶ _____	
<input type="checkbox"/> Created a pension plan (specify type) ▶ _____			
11 Date business started or acquired (month, day, year). See instructions.	12 Closing month of accounting year		
13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.	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. <input type="checkbox"/>		
Agricultural	Household	Other	
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.			
<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Transportation & warehousing	<input type="checkbox"/> Health care & social assistance
<input type="checkbox"/> Real estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Finance & insurance	<input type="checkbox"/> Accommodation & food service
		<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Wholesale-agent/broker
			<input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.			
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input type="checkbox"/> 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	Designee's telephone number (include area code) ()	
	Address and ZIP code	Designee's fax number (include area code) ()	
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.			Applicant's telephone number (include area code) ()
Name and title (type or print clearly) ▶			Applicant's fax number (include area code) ()
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	Needs an EIN to file Form 8832, Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes ⁸	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 Program Manager
 - b) If I am dissatisfied, or it is impractical for me to discuss my dissatisfaction with the Program 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