



When completed send to the appropriate volunteer council based on the county where you live (see bottom of this form)

APPLICATION FOR ASSISTANCE

Name of individual with disability		Last four digits of Social Security Number	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth	County of Residence
Home Phone			
Street or Box Address			
City		Zip Code	
Responsible Adult Name		Address	Phone
2nd Responsible Adult Name if Applicable		Address	Phone
Total children in family	Total adults in family	No. children with disabilities	No. adults with disabilities
Name of Person Who Referred You to Us		Their Agency/Organization	
Address of Referring Person		Phone	

Disabling Conditions (check all that apply):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Seizure Disorder/Epilepsy | <input type="checkbox"/> MR & MI Dual | <input type="checkbox"/> Deaf Blind |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Paraplegia | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Quadriplegia | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Neurologic Disorder | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Orthopedic Disorder | <input type="checkbox"/> Visual Imp./Blindness | <input type="checkbox"/> Hearing Imp./Deafness | |
| <input type="checkbox"/> Other | _____ | | |

Please describe your need or needs at this time?

We ask for the following information just for our records and it has no effect on your receiving help from us:

Race: Caucasian Hispanic Afro-american Native American Oriental Other

Currently Getting Help From:

- Medicaid Medicare Private Insurance SSI Dept. of Mental Retardation
 Dept. of M. Health Found. Voc. Rehab. Serv. AFDC/FAPRA Children's Rehab. Serv. Head inj.
 Community Action A church Epilepsy Found. Catholic Soc. Services Other

PERMISSION TO RELEASE INFORMATION

All the above information is true to the best of my knowledge, and I give my permission for the following individual or agency to release information about myself or my family member listed above for the purpose of determining eligibility for assistance from the Individual & Family Support Service. I know this information will be private and used only to determine if I or my family member is eligible for services. I also know that my permission is voluntary and at any time can be refused to any individual or agency listed below in the DISABILITY VERIFICATION section (fill in Printed Name or Agency/ Organization below).

The information checked below may be exchanged to determine eligibility:

- Medical reports/records Progress reports Psychological test results
 Social/developmental history Therapy testing reports Speech/language testing reports
 Screening or intake information Staffing reports vision/hearing records
 Developmental testing records Other _____

This release will be effective for _____ 90 days _____ 6 months _____ 1 year.

Signature

Please print name

Date

DISABILITY VERIFICATION

Note:

Verification of the disability must come from someone other than the individual requesting assistance or a family member. Common sources of verification are doctors, social workers, special ed. school personnel, service providers such as Children's Rehabilitation Service, UCP, Easter Seals, ARC, Vocational Rehabilitation Service, and Alabama Institute for Deaf and Blind.

A professional who can verify the Disability or Traumatic Brain Injury must sign below.

Description of Disability:

Verified by:

Signature

Printed Name

Agency/ Organization

Address

Phone

Applications for Assistance may be mailed to the following local volunteer councils based on the county in which you live: **Mobile or Washington**, Mobile Area Community Support Council, Attn: Ms. Susan Polizzi, 1050 Government Street, Mobile, AL 36604; **Baldwin**, Baldwin Community Support Council, Attn: Ms. Susan Polizzi, 1050 Government Street, Mobile, AL 36604; **Monroe, Escambia, or Conecuh**, Southwest Alabama Community Support Council, Attn: Ms. Vicki Dunning, P.O. Box 964, Monroeville, AL 36402; **Clarke**, Clarke Community Support Council, Attn: Ms. Betty Gilchrist, 711 Gilchrist Road, Grove Hill, AL 36451; **Dallas, Wilcox or Perry**, Cahaba Community Support Council, Attn: Ms. Odessa Taylor, 2906 Citizens Parkway, Selma, AL 36701

03/15/11