VCIL Vermont Center for Independent Living

People with disabilities working together for dignity, independence and civil rights

Vermont Equipment Distribution Program (EDP) Application

Name: _____ Birthdate: _____ County: _____

Gender: _____ Email: _____

Phone – cell: _____ Home: _____ (__voice; __TTY; ___VP)

Physical address: _____ City_____, VT _____

Mailing address, if different: _____

Emergency contact person: _____ Phone: _____
(___ voice; ___ TTY; ___ VP)

Relationship: _____ Email: _____

OPTIONAL **Ethnicity:** ☐Hispanic/Latino ☐Other
Race: ☐White ☐Black or African American ☐Asian
☐American Indian/Alaskan Native ☐Native Hawaiian or Other Pacific Islander

*Annual Household Income $_____ Number of household members:_____
*Please include all income for all household members

What are your specific disabilities? (example: Hard of Hearing, Deaf, etc.)

_____

_____

Please attach PROOF of your disability from ONE of the following sources:

- Speech-Language Pathologist
- Licensed Audiologist
- Doctor
- State Agency (Vocational Rehab)
- Special Education Individualized Educational Plan (IEP)

11 East State Street, Montpelier, VT 05602
802-229-0501, 800-639-1522 (voice & TTY)
fax: 802-229-0503, email: info@vcil.org, website: www.vcil.org

- **Please describe your communication barrier and how it relates to your disability.** (Please use the back of this page if you need more room)
- _____
_____
_____
_____

PLEASE ATTACH these items for your application to be considered:

☐Verification of disability (see page one of this application)
☐Income verification (copy of ONE item: VT Income Tax Return (form HI-144 or IN-111); telephone bill showing Lifeline credit; benefit letter for Supplemental Social Security Income (SSI); benefit letter from Dept of Children and Families showing Reach Up Grant or 3SqVT).

☐ Information on Confidentiality and Appeals (included below)
☐Consumer Eligibility Form (included below)
☐Release of Information (included below)

IMPORTANT:
ALL EQUIPMENT IS PROPERTY OF THE EDP and it is on **long term loan** to you. If you no longer need the equipment or move out of state, **equipment should be returned to VCIL, 11 East State Street, Montpelier, VT 05602.**

**Please initial here that you understand that equipment is a long term loan:* _____*

The Applicant certifies that all information in this application, and all information furnished in support of this application, is given for the purpose of obtaining some grant funds and is true and complete to the best of the Applicant's knowledge and belief.

_____ _____ _____
Applicant Date Program Coordinator Date

Information on Confidentiality and Appeals

Confidentiality

VCIL works to keep records confidential. You may be asked to sign a "Release of Information" form that will allow the staff of the Equipment Distribution Program (EDP) to work with partner organizations. You will also be asked to share documentation to help determine your eligibility for the program. This information will be held confidential by VCIL staff.

On occasion, VCIL is audited by the federal and state government, who are funders of the EDP. These audits include looking at peer files. This information will not be shared publicly, but there is an expectation that VCIL allow auditors to look at our records.

VCIL does not discriminate on the basis of race, national origin, religion, marital status, gender, sexual orientation, age and/or disability.

Appeals

VCIL has a grievance procedure. If you believe you have been discriminated against or want to file a grievance because you believe you were treated unfairly, please contact the coordinator of the EDP Program or their direct supervisor the Deputy Director for information on how to file a grievance.

If you would like assistance from someone other than a staff member of VCIL to help you file a grievance you can contact the Client Assistance Program (CAP). The Client Assistant Program address is 57 North Main Street, Rutland, VT and their toll free phone number is 1-800-889-2047(V/TTY).

I am signing this document to acknowledge I've received this information.

_____ _____

Signature of Participant Date

VTEDP Release of Information

The Vermont Center for Independent Living (VCIL) has an obligation to keep your personal information, identifying information, and records confidential. However, VCIL will need to share some of your information to determine eligibility for the Equipment Distribution Program (EDP).

I understand VCIL may share my name, contact information, medical condition, and financial information with one or more of the following entities:

Harris Communications	
	Other:

I authorize VCIL to contact the medical professional serving my physical needs:

_____ _____

(Print Name of Medical Professional) (Med Professional's Phone Number)

Do not release my information to: _____

I understand:

My information may be shared by phone, fax, mail, or e-mail. _____ (please initial)

I do not have to sign a release form, but I understand that not signing this form may result in being ineligible for EDP. _____ (please initial)

Releasing information about me could give another agency or person information about my location and confirm that I have been receiving services from VCIL. _____ (please initial)

I, _____,understand that this release is valid
(Print Applicant Full Name)

when I sign it and that I may withdraw my consent at any time either orally or in writing.

Signed:_____

Date:_____

This form expires one year after date of signature

Consumer Eligibility Form

To be eligible for Vermont Center For Independent Living services, a person must experience a significant disability which limits their ability to function independently. In order to document that you are eligible for our services, please answer the following questions:

I, _____, state that I have one or more of the following the following disability types (circle all that apply):

Cognitive Deaf Mental/Emotional Physical Vision Other (specify)

Date of Birth _____ Town of Residence _____

My disability(ies) substantially limits me from functioning independently in the following area(s):

_____self-care
_____mobility
_____education
_____employment
_____housing
_____Other (specify): _____

The services I am requesting will help me: (Check all that apply)

___improve my ability to function in my family or community
___maintain my ability to function in my family or community
___obtain, maintain or advance in employment

I understand that it is my choice to have services provided to me under an Independent Living Plan (a formal plan which states my goals and services I will receive) or I can choose not to have such a plan (Waiver). I choose:

___ Independent Living Plan ___ Waiver

_____ _____
Consumer's Signature Date

By signing below, I determine as a representative of the service provider that the applicant is eligible for services and has met the basic requirements specified in Section 364.40. The consumer has received information about the Client Assistance Program (CAP).

_____ _____
VCIL Signature Date

NORTH SOUTH
09/19/2018