CASE FILE CHECKLIST

Consumer: _____ ILS:_____

Form	Review	present	complete	signed	current
Referral	initial				
Intake	initial				
Application for Services	initial				
Consumer Eligibility Form	initial				
ILP	initial/ yearly				
Rights Page/ILP Waiver (match ILP)	Initial/ yearly				
Goal Assessment	Initial/ yearly				
Housing and Voting Questionnaire	initial				
Financial Tool (optional)	initial				
Program Participation Form	initial				
Release of Information	yearly				
Worksheet	PRN				
Equipment transfer	PRN				
Case notes	current				
Closure Form	Close				

SERVICES APPROPIATE FOR DISABILITY: _____
EXPLAIN: _____
CASE NOTES: COMPREHENSIVE – CURRENT: _____
CLOSURE/SIGNED:_____
COMMENTS/CONCERNS:_____
_____

REVIEWED BY:_____ DATE: _____

disABILITY LINK's POLICY FOR GRIEVANCE FOR CONSUMERS OR COMMUNITY MEMBERS

POLICY: disABILITY LINK is interested in responsiveness to the people of our community. In conjunction with this, we are interested in providing the opportunity and means for community members to register their concerns or complaints when decisions concerning them or services provided to them are considered unsatisfactory by that community member.

PROCEDURE:

1) The consumer or community member should discuss a complaint or grievance with the staff member involved. The consumer or community member will be given a copy of any written policy or and complaint process applicable to his or her complaint.

2) When solved at this level, the staff member shall make an entry in the case record, if any, and advise his/her immediate supervisor. If the complaint is not satisfactorily resolved, the consumer or community member may appeal verbally or in writing to the immediate supervisor of the staff person. The immediate supervisor shall respond to the complainant within seven (7) days. If the complaint was in writing, the response will be made in writing.

3) If the consumer or community member is still dissatisfied, he/she may appeal in writing to the Executive Director. The Executive Director will issue a final decision within fifteen (15) days unless a delay is justified in writing.

4) Complaints will be resolved in accordance with written policy and procedure. Consumers or community members requesting a change in organizational policy are encouraged to write to the Executive Director for consideration of their recommendations for policy change.

5) At the time of request for service, consumers will be given a copy of the CAP program brochure and informed of disABILITY LINK's Complaint procedure. A copy will be posted in common area for consumers.

disABILITY LINK
the center for rights & resources

CLIENT'S RIGHTS

1. **APPLICATION**: You have the right to apply or reapply for Independent Services.

2. **ELIGIBILITY**: You have the right to an evaluation to determine if you are eligible for services.

3. **PARTICIPATE IN PROGRAM PLANNING:** You have the right to be a partner in the planning of your IL goals, services and to choose the service vendor.

4. **CONFIDENTIALITY:** All Information given to your IL Specialist will be used only for your Independent Living Program.

5. **CASE FILE:** You have the right to view and copy information in your file; provided it is not provided by another agency. Copies in excess of ten pages will be at the consumers cost.

6. **CLOSURE:** You have the right to be consulted before your IL Specialist closes your case.

7. **NON-DISCRIMINATION:** You have the right to be provided IL services in a non-discriminatory manner without regard to race, color, creed, sex, national origin or disability.

8. **CLIENT ASSITANCE PROGRAM (CAP):** You have the right to be provided information concerning the availability of CAP.

9. **APPEALS PROCESS:** You have the right to access DISABILITY LINK's appeal process.

disABILITY LINK
the center for rights & resources

OVERVIEW OF SERVICES

Individuals often come to Independent Living knowing very little about the Philosophy of Independent Living. This overview is to assist in your understanding of our services.

Please let your Independent Living Specialist (ILS) know what your needs and expectations of Independent Living (IL) are so that we can address them in a **partnership.** disABILITY LINK is consumer based and services are provided according to your unique IL need. To be eligible for services an individual must have a significant long term disability that interferes with living independently. The individual must be motivated to maintain and/or increase their own levels of independence by participating actively.

The following statements are to help you understand our services:

- You will be treated courteously, professionally and with respect.
- disABILITY LINK's intention is to give as many options as possible so you can make an informed choice.

- disABILITY LINK's goal is to help facilitate your goal to increase or maintain your independence as much as possible.

- disABILITY LINK's budgets are limited, therefore:
  - Your Specialist will ask you to contribute as much as possible in-kind or financially (this supports the concept of maintaining independence) when obtaining non-cost services.
  - Only services related to your disability are provided
  - You will be asked to help locate and contact other resources that may be able to help with your request for services.

- Consumer involvement in their IL case is critical. You are expected to be a full partner in decision making, working toward your IL goal and sharing costs if possible.

- Everyone is treated as an individual. Services are provided based on the individual's needs and circumstances.

- You have the right to appeal decisions in your case. Tell your Specialist if you disagree with a decision. If this does not resolve the issue then please follow the policy for grievances.

CONSUMER RESPONSIBILITIES

- To participate in developing your IL Plan.
- To follow through with responsibilities in your IL Plan.
- To immediately tell your Specialist about anything that may affect your IL Plan.
- To keep all appointments.
- To treat IL Specialists with courtesy
- In the case of a waived IL Plan, consumer is expected to actively participate.

ADDITIONAL INFORMATION

- This is not an entitlement program. This means that both you and the specialist must work together.
- Funding will be sought out from resources as a combined effort between you and your IL Specialist. We work with other organizations and resources to combine funds to meet the needs identified if at all possible.
- All spending in your IL case must be authorized prior to the service being provided. NEVER assume IL will pay for anything.
- You must communicate honestly and in a timely manner with your Specialist. Keep in contact with your Specialist at least monthly.
- Goals are not completed over night. There is a possibility of success as well as failure. Keep in mind this follows the Independent Living Philosophy.
- Have questions, ask.

disABILITY LINK

Referral Information Form

Date of referral:_____

Staff Referring :_____ ILS Assigned:_____

Referral's Name:_____

Address:_____

City:_____ State:_GA___ ZIP:_____

County:_____ Phone #:_____

DOB:_____ Gender:__Female ___Male

Racial or Ethnic Group: __American Indian/Alaskan __Asian/Pacific Islander__Hispanic/Latino __White/Caucasian __Black/African American __Other

Source of referral: (circle one) Consumer Educator Employer Vendor Rep/Family member Service Provider

Other (state):_____

Contact Method (circle one): Large Print Braille Audio Tape Diskette Email Standard Email Large Print

Consumer's consent for referral: ___Yes ___N0

Presenting Concern :_____

_____

ILS referred individual to:_____

Notes:_____

_____

The Rehabilitation Act Amendments of 1992 define someone with a significant disability as one who:" has a severe physical and /or mental impairment and whose ability to function independently in the family or community or to obtain, maintain, or advance in employment is substantially limited, and for whom the delivery of independent living services will improve the ability to function, continue functioning, or move towards functioning independently in the family or community or to continue in employment respectively."

disABILITY LINK

APPLICATION FOR SERVICES

My signature to this document constitutes an application for Independent Living Services as provided by for Federal law (P.L. 95-602). I understand that such aid as may be given to me is for the sole purpose of assisting me to increase or maintain my independence. If I am found eligible for services, a reasonable amount of help will be given to me for that purpose. However, specific services or independence cannot be guaranteed.

disABILITY LINK will gather information with me personally, and/or with my written consent to establish eligibility and develop my Independent Living Plan (ILP).

Information from my case file will not be disclosed directly or indirectly other than in the administration of my independent living program unless my informed, written consent has been obtained.

disABILITY LINK does not discriminate on grounds of race, color sex, age, creed, national origin, or disability in providing any services, financial aid or other benefits to individuals under the program. I understand that I can appeal any discriminatory practices.

To be eligible for services, I understand that I must have a presence of a significant disability that interferes with living independently and a signed certificate of eligibility. I also understand that I must be motivated to maintain and/ or increase my levels of independence by participating actively in my independent living plan. All services paid for by IL must be authorized in writing before they are delivered. Without prior authorization, payment will be refused.

_____ _____

Consumer signature or Representative Signature Date

_____ _____

IL Specialist Date

disABILITY LINK
Application / ILP- Amendment / Closure
Client Rights/ Approval or Waiver of Independent Living Plan

disABILITY LINK's number one goal is to partner with you to help you maintain or increase your independence. In the event of being dissatisfied with any decisions concerning the delivery or denial of services, you have the right to appeal the decisions of the IL specialist in accordance with disABILITY LINK's policy for Grievance for Consumer and Community Members.
Furthermore, you have the right to discuss any questions or problems with the Client Assistance Program (CAP).
I have received a CAP Information._____ (Consumer Initials)

Approval of ILP
I have received an explanation of disABILITY LINK's Independent Living (IL) services and the option to waive the development of an Independent Living Plan (ILP). The goals contained in this ILP are my goals which I have created with a disABILITY LINK staff member. I understand that I will need to verify completion of said goals to my satisfaction, with a signature, initials or mark. I also understand my goals will be recorded as part of the information retained in my confidential CSR.
I have chosen this option:_____(Consumer Initials)

Waiver of ILP
I have received an explanation of disABILITY LINK's Independent Living (IL) services and the option to waive the development of an Independent Living Plan (ILP). I knowingly and voluntarily choose not to create an ILP. I understand DISABILITY LINK will record goals established through services requested and/or provided to me even though I waived my ILP. I also understand I may create an ILP at a later date.
I have chosen this option:_____(Consumer Initials)

_____ _____
Consumer/Representative Date

_____ _____
IL Specialist Date

disABILITY LINK
FINANCIAL TOOL

Consumer: _____Date:_____
Insurance Policy # / Group #: _____
Medicare: _____ Medicaid: _____Other: _____

Monthly Income	**Dollar Amount**	**Monthly Expenses**	**Dollar Amount**
Wages		Rent / Mortgage	
a. Self		Home Insurance	
b. Spouse		Cable TV	
SS Retirement		Gas	
a. Self		Electric	
b. Spouse		Water	
Pension		Trash	
SSDI		Telephone	
SSI		Medical	
Public Assistance (AFDC, Food Stamps, ETC.)		Dental	
		Medications	
Worker's Comp		Transportation	
Unemployment		Auto Insurance	
Veterans Benefits		Auto Gas	
Rental Property		Auto Payment	
Stocks, bonds, etc.		Alimony / Child Sup.	
Other		Groceries	
		Health Insurance	
		Loan Payments	
		Recreation	
		Credit Card payments	
		Other	
TOTAL		**TOTAL**	

<u>Financial Tool:</u> I understand no person will be discriminated against because of their income. This tool is to assist the ILS in making appropriate referrals to resources in the community and is voluntary. This information will remain confidential.

_____ _____
Consumer/Representative Signature Date

disABILITY LINK

INTAKE SHEET

Name:_____
First (required) Middle Initial Last (Required)
Address: _____

State: GA Zipcode:_____County:_____

Social Security Number:_____ Email: ____

Exclude from Mailing list: __ Head of Household: __No __Yes

Phone 1:Telephone Type:____ Number:_____

Phone 2:Telephone Type:_____ Number:_____

*Ethnic Origin: ___Hispanic/Latino __Other Race:_____

Sex: Male □ Female □ DOB:_____ Marital Status: __

Who referred you ? _____Date referred: _____

Contact Type (circle one): Consumer (self) Educator Employer Other Rep or Family Member Service Provider Vendor

Do you have a legal guardian or power of attorney (POA)? Yes ___No ___

Guardian or POA: _____
Name Address Telephone

Veteran: ____No Are you connected to other Veteran Services? _Yes _No

Disability(s):_____

Physician:_____
Name Telephone
Education: _____Vocation: _____

Previous Rehabilitation Services (PT, Voc Rehab, etc.): _____

Other Agencies Currently Involved:

Home Health	□	LIHEAP	□	School	□
Public Health	□	CDCP	□	DFACS	□
VA	□	GVRA	□	NFB	□
State program for Visual Impaired			□	TANF	□
State program for Hearing Impaired	□	Mental Health Services			□

Other:_____

Would you like to information for SNAP (food stamp) benefits? __Yes __No

Income Level:_____

Is your financial situation manageable? Yes _____ No _____

Explain: _____

Do you feel confident about making decisions that affect your own well-being? Yes ___ No _____

Explain: _____

Are you aware of the laws and the rights of people with disabilities?

Yes _____ No ___

_____ _____

Consumer signature or Representative Signature Date

_____ _____

IL Specialist Date

Consumer Eligibility Form

To be eligible for disABILITY LINK's independent living services, a person must experience a significant disability that 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 the following significant disabilities:

Please mark those applicable:

___Cognitive

___Mental/ Emotional

___Physical

___Hearing

___Vision

___Other

My disability impacts me with:

___Self-care

___Education

___Mobility

___Employment

___Housing

___Other

The service 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

Primary Diagnosis: _____

Secondary Diagnosis if applicable:_____

_____ _____

Consumer/Representative Signature **Date**

By signing below, I determine as a representative of the service provider that the applicant has met thee basic eligibility requirements of disABILITY LINK.

_____ _____

ILS Signature **Date**

Achieving your own Independence
Developing Your Independent Living Plan/Goal Assessment/Worksheet

The Independent Living Services (ILS) specialist helps individuals with significant disabilities figure out and set goals to live more independently. The role of the ILS is to help you decide the goals you want, the steps needed to achieve your goals and to provide you with the support you need with each step along the way. These goals and the steps needed to achieve your goals are called an Independent Living Plans (ILP). An ILP outlines, very clearly, what you are working on.

The ILS can help you develop an ILP to reach goals, or you can choose not to have an ILP. Either way, the work you do together will be focused on the goals that you decide to work toward. Goals can be changed or added to the ILP at any time.

1. Be positive when writing your goal.
   Example Goal: I want to find a job so that I can have my own money.
2. To achieve positive results we need to create and carry out a set of positive instructions.
   - Write goals that you want to achieve.
   - Write goals that involve your behavior, not someone else's behavior
   - Write your goal in first person/present tense
   - Write your goals out in complete detail, if it is a big goal divide it into smaller steps or into more than one goal

   Example:

   Goal: I want to find a job.
   - Think about *how* you will measure the success of your goal
   - Include start date and projected date of completion
   - Review Sample Goals

1. My Goal is:_____

2. I would feel successful if:_____

GOALS ASSESSMENT

Please describe what level of assistance you need in each of these areas.
1. Never 2. Sometimes 3. Usually 4. Always

A) Self Advocacy-Self Empowerment
- 1) Systemic 1 2 3 4
- 2) Individual 1 2 3 4

B) Communication
- 1) Reading 1 2 3 4
- 2) Writing 1 2 3 4
- 3) Speaking 1 2 3 4
- 4) Hearing 1 2 3 4
- 5) Vision 1 2 3 4

C) Mobility-Transportation
- 1) In your Home 1 2 3 4
- 2) In the Community 1 2 3 4

D) Community Based Living
- 1) Housing 1 2 3 4
- 2) Housekeeping 1 2 3 4
- 3) Cooking 1 2 3 4
- 4) Home Maintenance 1 2 3 4

E) Educational
- 1) Attaining GED, HS/College Degree, Tutor 1 2 3 4

F) Vocational
- 1) Finding or maintaining Employment 1 2 3 4
- 2) Job Training, coaching 1 2 3 4

G) Self-care
- 1) Personal hygiene 1 2 3 4
- 2) Nutrition/Med./Safety 1 2 3 4

H) Information Access/Technology
- 1) Technology Skills: List need:_____ 1 2 3 4

I) Personal Resource Management
- 1) Quality of Life Skills/IL Skills 1 2 3 4
- 2) Health, financial, budgeting, rights & benefits 1 2 3 4

J) Relocation from a Nursing Home 1 2 3 4

K) Community/ Social Participation 1 2 3 4

L) Other/goals not listed (explain)_____ 1 2 3 4

_____ _____ _____

Signature of Consumer/Representative Date

disABILITY LINK
Independent Living Plan
Original / Amendment

Consumer:_____
Goal Category:_____
Independent Living Goal:_____

IL Plan:

- ☐ Accepted
- ☐ Waived
- ☐ Dropped

Consumer is the Person Responsible for ALL Action Steps.	Start Date	Anticipated Date of Completion	Completion Date
Step 1:			
ILS Support:			
Step 2:			
ILS Support:			
Step 3:			
ILS Support:			
Step 4:			
ILS Support:			
Step 5:			
ILS Support:			

I have worked jointly with the IL Specialist in documenting this plan and we will work together to accomplish the Goal.

_____ _____
Signature of Consumer/ Representative Date

_____ _____
Signature of IL Specialist Date

Closure Summary

Date_____
Name:_____

I have been given the opportunity to review and/ or revise my ILP and redevelop my goals if necessary.
I agree with closure Yes_____No_____.

I understand my case is being closed for the following reason:
___I have successfully completed my goals.
___Other reason:_____
These services were provided:

__Advocacy/Legal Services
__Assistive Technology
__Children's Services
__Communication Services
__Counseling and Related Services
__Family Services
__Housing, Home Modifications and Shelter Services
__IL Skills Training and Life Skill Training Services
__Information and Referral Services
__Mental Restoration Services
__Mobility Training
__Peer Counseling Services
__Personal Assistance Services
__Physical Restoration Services
__Preventative Services
__Prostheses, Orthotics and other Appliances
__Recreational Services
__Rehabilitation Technology Services
__Therapeutic Treatment
__Transportation Services
__Youth/Transition Services
__Other Services: Please list:
_____
_____

_____ _____
Signature of Consumer/ Representative Date

_____ _____
Signature of IL Specialist Date

Release of Information

I give disABILITY LINK permission to contact the entity designed below for the purpose of releasing and/ or receiving information regarding Independent Living Services for one year from the date signed. I understand that this information will be kept confidential and will not be discussed with or released to anyone other than the entity specified in this release.

I understand that by law I need not consent to the release of any information. However, I choose to do so willingly and voluntarily to further my purpose of achieving independent living. I also understand that I may revoke consent at any time, except when action has already been taken on my behalf.

(The consumer is entitled to a copy of this authorization upon request.)

Authorized contact:

This release expires in one year and is in effect until:

Consumer/ Representative: **Date:**

IL Specialist Signature: **Date:**

Program Participation and Authorization for Publicity

disABILITY LINK thanks you for your interest in attending our activities and services. disABILITY LINK cannot accept liability for your personal needs, your personal safety or health, or the loss or damage to your personal property. disABILITY LINK commits to providing you with a safe, clean and accessible environment and will make reasonable accommodations upon request. We will treat you with courtesy and respect and ask that you do the same with our staff, visitors and equipment.

As your local independent living center we would like to be able to share your experience in order to benefit the disability community. disABILITY LINK has numerous publications, including but not limited to pamphlets, videos, presentations, and social media sites such as our webpage, Facebook and twitter. In addition, disABILITY LINK is active in advocacy, training, and outreach efforts throughout the community, state and nation.

Please select the option of your choice:

☐ I give my authorization for publicity

☐ I do NOT give my authorization for publicity

Your signature/Parent/Guardian below indicates that you have reviewed, understood, and agreed to the terms above. In addition, you agree to give disABILITY LINK permission to use your photograph, writings, testimonials, or short biography in image, text, video, and audio publications as part of our outreach efforts unless otherwise marked above. The above material becomes the property of disABILITY LINK.

You may revoke your consent to publicity at any time.

Consumer/ Representative:	**Date:**

IL Specialist Signature:	**Date:**

Health and Wellness Survey

This survey is a used to support individuals in enhancing their quality of life and is completely voluntary.

Question	Yes	No
1. Are you satisfied with where you live?		
2. Do you have access to medical care and medication?		
3. In an emergency, do you have someone to call?		
4. Do you have a telephone?		
5. Do you have a Primary Care Physician?		
6. Do you have the disability-related assistive devices, equipment and medical supplies you need?		
7. Do you have a way to get to where you need or want to go?		
8. Do you have an income?		
9. Do you need assistance in finding or maintaining employment?		
10. Do you do participate in activities to keep your spirit healthy and fit?		
11. Do you have a hobby or an interest? Any activities you participate in? Ones you'd like to try? (Please list):		
12. Is there something you'd like to learn that would make you more independent or just something you would like to learn? (Please list):		
13. Do you think you have access to enough healthy and nutritious meals?		
14. Do you participate in activities that keep your body healthy and fit?		
15. Are you interested in learning more about health and fitness activities?		
16. Would you like to share your skills and experiences by being a peer supporter and providing support to others?		
17. Do you need help with self-advocacy?		
18. Would you like to join the Disability Rights Movement and become an advocate for Persons with Disabilities?		

Notes:

Disclaimer: disABILITY LINK is a consumer directed disability organization. The Health and Wellness survey is a service of disABILITY LINK, available to people with disabilities to enhance their quality of life. While every effort is made to ensure the accuracy of the information,

we make no guarantees. The recommendation of an organization or service does not imply an endorsement of the organization or service, nor does exclusion imply disapproval. Under no circumstances shall DISABILITY LINK or its employees be liable for any direct, indirect, incidental, special, punitive, or consequential damages which may result in any way from your use of the information included as part of this Survey.
My signature below signifies that I have reviewed the checklist responses with the Independent Living Specialist and have read and understand the disclaimer.

_____

Signature

_____

Date

HOUSING INFORMATION AND VOTER QUESTIONNAIRE

Question	Yes	No
1. Have you looked for and been denied rental housing in the last two years?		
2. Have you made any request for help by your landlord that was denied in last two years?		
3. Were you threatened with eviction from rental housing in last two years?		
4. Were you evicted from rental housing in last two years?		
5. Were you denied or refused in attempting to buy a home within the last two years?		
6. Have you tried to inspect a possible apartment/house to live in but been shown a different one to look at within the last two years?		
7. Have you requested and been denied a reasonable modification/accommodation by your landlord within the last two years?		
Explanation of any Yes answer:		

Your voter registration information will be kept confidential. If you would like help filling out the voter registration application form, we will provide assistance to you. You may also fill out the application in private.

If you are not registered to vote, would you like to apply to register to vote here today?

__Yes, I will take the registration home and fill it out myself.

__Yes, I would like the agency staff to help me fill out the registration and mail it for me.

__No, I would not like to register to vote at this time.

__No, I am already a registered voter.

_____ _____

Signature of Consumer/ Representative Date