THE ABILITY CENTER™
MAKING INDEPENDENCE POSSIBLE SINCE 1920

Home Accessibility Program Application

THE ABILITY CENTER
of Greater Toledo
5605 Monroe Street
Sylvania, OH 43560
419-885-5733
Toll Free 866-885-5733
Fax 419-882-4813
www.abilitycenter.org

Bryan Office
1425 E. High Street, Suite 108
Bryan, OH 43506
419-633-1400
Toll Free 855-633-1400
Fax 419-633-1410

Housing Resource Center
Fax: (419) 517-1360

Date Sent: _____

Date Received: _____

Consumer Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Birth date: _____ Email: _____

Please complete this form and return it to The Ability Center. Enclose copies of current proof of income.

The Ability Center's funding sources require that we verify your income status, as well as whether or not you are current with your property taxes. The Ability Center cannot process applications from homeowners with overdue taxes!

Do you own your home? ◯ Yes ◯ No

How long have you lived here? _____

How long do you plan on remaining at this address? _____

Number of bedrooms:

Building Type (*Check one*):

- ◯ Single Family
- ◯ Duplex
- ◯ Trailer
- ◯ Apartment Complex

Landlord/Apartment Manager or Home Owner Information *(as applicable)*

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

H Phone: _____ W Phone: _____

Can The Ability Center use photos of your project? (Yes or No) _____

I give permission for the Ability Center of Greater Toledo to use my name or my child's name, photograph(s) and/or videos of us in any publications or publicity released to the public.

I agree that we can participate in interviews and have ACT representatives quote us in the press. This includes but is not limited to newsletters, press releases, direct mail solicitation letters, brochures, websites, and annual reports.

According the US Census Bureau, Race and Hispanic origin are two separate concepts in the federal statistical system. Hispanic is no longer considered a race} but rather an ethnicity. Members of any race may be Hispanic. People in each race group may be either Hispanic or Not Hispanic. Each person has two attributes: their race (or races), and whether or not they are Hispanic.

Source: US Census Bureau, Population Division, Social and Demographic Statistics.

To remain compliant with our Grant Monitors, please check which race you identify with. If you identify with being a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race} check the Hispanic Ethnicity box next to the race you are selecting. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

You may check more than one category, i.e. you can be both African-American, Hispanic ethnicity, female head of household and a handicapped person.

	Race	**Hispanic Ethnicity**
A. White	☐	☐
B. Black, African American	☐	☐
C. American Indian / Alaska Native	☐	☐
D. Asian	☐	☐
E. Native Hawaiian other Pacific Islander	☐	☐
F. American Indian, Alaska Native and White	☐	☐
G. Black, African American and White	☐	☐
H. American Indian, Alaska Native and Black, African American	☐	☐
I. Asian and White	☐	☐
J. Other Multi-Racial	☐	☐
K. Female Head of Household	☐	☐
L Handicapped Person	☐	☐

Disability:

To help us better identify appropriate resources for you, please check what disability/disabilities you identify with.
If you select multiple disabilities, please let us know what you consider to be your primary disability by circling that selection.

- ☐ Alzheimer's Disease
- ☐ Amputation
- ☐ Arthritis
- ☐ Autism Spectrum Disorder
- ☐ Back Injury
- ☐ Blind/Visual Impairment
- ☐ Burn Injury
- ☐ Cancer
- ☐ Cardiac/Circulatory
- ☐ Cerebral Palsy
- ☐ Cognitive/Developmental Disability
- ☐ Cystic Fibrosis
- ☐ Deaf/Hearing Impairment
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Emotional/Behavioral Disability
- ☐ Endocrine/Metabolic Condition
- ☐ Epilepsy
- ☐ Head Injury (TBI)
- ☐ HIV/AIDS
- ☐ Learning Disability
- ☐ Mental Illness
- ☐ Muscular-Skeletal
- ☐ Multiple Sclerosis
- ☐ Neurological Condition
- ☐ Physical Disability
- ☐ Renal Disease
- ☐ Respiratory/Pulmonary Condition
- ☐ Sickle Cell Anemia
- ☐ Speech Impairment
- ☐ Spina Bifida
- ☐ Spinal Cord Injury
- ☐ Stroke

Other: _____

Employment: (Please select your current employment status)

- ☐ Full Time
- ☐ Part Time
- ☐ Not Employed/Seeking Work
- ☐ Not Employed/Not Seeking Work
- ☐ Retired
- ☐ Sheltered Employment
- ☐ Supported Employment
- ☐ Transitional

Healthcare:

- ☐ Medicare
- ☐ Medicaid
- ☐ Dental Insurance
- ☐ Vision Insurance
- ☐ VA Benefits
- ☐ Private Insurance

Other _____

Marital Status

- ☐ Married
- ☐ Living with Significant Other
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Widow/Widower

Education: (Please select highest level completed)

- ☐ Special Education/Certificate
- ☐ 8th Grade or Less
- ☐ Some High School
- ☐ High School Diploma/GED
- ☐ Trade/Vocational
- ☐ Some College
- ☐ College Degree
- ☐ Graduate Degree
- ☐ Doctorate Degree

Current Housing

- ☐ Rent House/Apartment
- ☐ Own House
- ☐ Family
- ☐ Group Home
- ☐ Homeless
- ☐ Assisted Living
- ☐ Nursing Home
- ☐ Single Room Occupancy
- ☐ Hotel
- ☐ Transitional Housing

Names of Other Adults and Children Living In the Home

Name:		Relationship:		Age:	
Name:		Relationship:		Age:	
Name:		Relationship:		Age:	
Name:		Relationship:		Age:	
Name:		Relationship:		Age:	
Name:		Relationship:		Age:	

Please Provide Monthly Income of Every Individual in Household

You must include proof for all income claimed on this application. *All household residents must indicate the type and amount of income received.*

Acceptable Forms of Income Documentation

Last Three Consecutive Pay Stubs	**Signed Statement from Employer**
Latest Award Letters from Social Security	**Record of Bank Deposit**
Alimony Printouts from Issuing Agency	**Signed Zero Income Statement from Client**

Type of Income	**Monthly Amount Received**
Wages, Salary, Tips, Commissions, etc	
Non-Farm Self-Employment	
Farm Self-Employment	
Interests, Dividends, Rental Income, Real Estate Income	
Social Security Income or Railroad Retirement	
Supplemental Security Income, AFDC, or Other Public Assistance	
Pension/Annuity/Retirement	
Alimony, Child Support, Workers Compensation	
VA Benefits	
Other Income	

Total Monthly Income _____ **Annual Income** _____

Determination of Need

Please complete the following section of the form, doing so will help The Ability Center determine your need for a ramp or home modification.

Within the past 12 months:

Number of times you, or a family member, have needed medical attention due to a fall at your home:

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10 or more

Number of times you, or a family member, have been unable to return home from a rehab or nursing facility due to a lack of accessibility at your home. (Need a ramp/porch or stair lift/low-rise steps/handrails/grab bars/etc.

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10 or more

Number of times you, or a family member, have been unable to go to school, work, or access transportation services due to a lack of accessibility at your home.

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10 or more

Number of healthcare-related appointments you, or a family member, have been unable to attend due to a lack of accessibility at your home.

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10 or more

Number of times you, or a family member, have been unable to access friends, family, neighbors, church, or other social events due to a lack of accessibility at your home.

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10 or more

Which mobility device do you use? (Choose one):

◯ Manual Wheelchair ◯ Electric Wheelchair ◯ 3 or 4 Wheeled Scooter ◯ Walker or Cane

How wide is your wheelchair or scooter from widest points? _____

Measure precisely. This measurement ensures that your ramp is wide enough for your mobility device.

Does your wheelchair/scooter clear the doorway? _____

Which modification do you need most? (Choose one):

◯ Ramp ◯ Low-Rise Steps ◯ Handrails ◯ Grab Bars Other _____

Which door would you prefer to use for your project?: ◯ Front ◯ Side ◯ Rear ◯ Garage

What type of transportation do you use?

◯ TARPS/Ambulette Service ◯ Family ◯ Friends ◯ Personal Vehicle

Are you a Military Veteran? ◯ Yes ◯ No **Branch:** _____

Are you registered to vote? ◯ Yes ◯ No If "No", would you like assistance registering? _____

Please check if you are receiving services from any of these programs:

☐ Passport (Area Office on Aging) ☐ Level 1 or Individual Options (IO) (County DD)

☐ Ohio Home Care Waiver (ODJFS) ☐ MyCare Ohio Buckeye ☐ MyCare Ohio Aetna

☐ Hospice / Name of Hospice Provider _____

If yes, have you requested a home modification through this program? *(Yes or No)* _____

Name of Case-Manager _____

How did you learn about us?

☐ Self ☐ Presentation/Info Fair

☐ Service Provider (list below) ☐ Materials/Brochures

☐ Family or Friend ☐ Website/Social Media

☐ Staff/Board Member ☐ Other (list below)

_____

Consumer Living Arrangement Agreement

Dear Applicant,

When applying for a ramp or home modification The Ability Center ask that you remain at this address for at least one year from the date of this agreement. By signing below you are agreeing that you intend to live there for at least one year from the date of this agreement.

_____

Consumer Signature Date Signed

_____

Parent / Guardian Signature Date Signed

It is the policy of The Ability Center of Greater Toledo to provide equal employment and promotion opportunities and services to all persons without regard to race, creed, color, citizenship, sex, age, national origin, religion, sexual orientation or disability.

The Center operates and administers its programs and services without discrimination in the provision of those services. Additionally, The Center fully subscribes to the principles and intention of the Americans with Disabilities Act (ADA), which prohibits discrimination against persons with disabilities and expects all employees to support these principles as well.

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HRC Independent Living Plan

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Fax 419-633-1410

Housing Resource Center
Fax: (419) 517-1360

Date: _____

Name: _____

Birth Date: _____

This form is part of the application. Please complete this portion of the application and sign at the bottom of the page.

Housing Resource Center (HRC) Programs (Check all that apply)

- ☐ Home Accessibility Program
- ☐ Nursing Home Transition (HOME Choice)
- ☐ Individual and Systems Advocacy
- ☐ Check here if you would like more information on other Ability Center programs.

The following Goal Descriptions pertain to the reason why I am requesting assistance from the HRC. Check all that apply.

To increase my:

- ☐ Access to *Community Based Living (to leave a nursing facility/institution and return a community of my choice.)*
- ☐ Ability to *sustain independent living* in my current home.
- ☐ Home *safety* and to reduce falls within my home.
- ☐ Access to *healthcare* services (rehab, therapy, dialysis, pharmacy, medical appointments.
- ☐ Access to *Transportation* services (TARPS/DD/AOoA/School/Cab)
- ☐ Access to *Employment*
- ☐ Access to friends, family, neighbors, church, or other *Social* events.
- ☐ *Freedom of Choice and Opportunity.*
- ☐ Ability to represent myself and have a sense of *Empowerment.*
- ☐ Access to a *Benefit, Program, Service, or Activity.*
- ☐ Other _____

Please sign indicating that the above information is correct.

☐ Yes. I would like for the goal descriptions selected above to be incorporated into my Independent Living Plan.

☐ No. I waive my right to develop an Independent Living Plan

_____ _____

Signature of Applicant or Guardian ACT Staff Member

If you have complaints or concerns about our service, please direct them to 419-885-5733. If the issue is not satisfactorily resolved by The Ability Center, you may file a complaint through the Client Assistance Program of Disability Rights Ohio, at 800-282-9181.