



Home Accessibility Program Application

**THE ABILITY CENTER
of Greater Toledo**

5605 Monroe Street

Sylvania OH 43560

Phone: (419) 885-5733 V/TTY

Toll Free: (866) 885-5733

www.abilitycenter.org

Date Sent: _____

Date Received: _____

Consumer Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Social Security: _____ Email: _____

Birth date: _____ Disability: _____

Ottawa County Office

1848 East Perry Street, Suite 110

Port Clinton, OH 43452

Phone: (419) 734-0330

Toll Free: (877) 734-0330

Fax: (419) 732-6864

Bryan Office

1425 E. High Street, Suite 108

Bryan, OH 43506

Phone: (419) 633-1400

Toll Free: (855) 633-1400

Fax: (419) 633-1410

Housing Resource Center

Fax: (419) 517-1360

***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? _____

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 to 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	<input type="checkbox"/>	<input type="checkbox"/>
B. Black, African American	<input type="checkbox"/>	<input type="checkbox"/>
C. American Indian} Alaska Native	<input type="checkbox"/>	<input type="checkbox"/>
D. Asian	<input type="checkbox"/>	<input type="checkbox"/>
E. Native Hawaiian other Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
F. American Indian, Alaska Native and White	<input type="checkbox"/>	<input type="checkbox"/>
G. Black, African American and White	<input type="checkbox"/>	<input type="checkbox"/>
H. American Indian, Alaska Native and Black, African American	<input type="checkbox"/>	<input type="checkbox"/>
I. Asian and White	<input type="checkbox"/>	<input type="checkbox"/>
J. Other Multi-Racial	<input type="checkbox"/>	<input type="checkbox"/>
K. Female Head of Household	<input type="checkbox"/>	<input type="checkbox"/>
L Handicapped Person	<input type="checkbox"/>	<input type="checkbox"/>

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.

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

Other: _____

Employment: (Please select your current employment status)

- | | |
|--------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Full Time | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Part Time | <input type="checkbox"/> Sheltered Employment |
| <input type="checkbox"/> Not Employed/Seeking Work | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Not Employed/Not Seeking Work | <input type="checkbox"/> Transitional |

Healthcare:

- | | |
|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> VA Benefits |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> Dental Insurance | Other _____ |
| <input type="checkbox"/> Vision Insurance | |

Marital Status

- | | |
|--------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Living with Significant Other | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Single | <input type="checkbox"/> Widow/Widower |

Education: (Please select highest level completed)

- | | |
|--------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Special Education/Certificate | <input type="checkbox"/> Some College |
| <input type="checkbox"/> 8th Grade or Less | <input type="checkbox"/> College Degree |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Graduate Degree |
| <input type="checkbox"/> High School Diploma/GED | <input type="checkbox"/> Doctorate Degree |
| <input type="checkbox"/> Trade/Vocational | |

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.



HRC Independent Living Plan

Date: _____

Name: _____

Birth Date: _____

Social Security: _____

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

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Housing Resource Center

Fax: (419) 517-1360

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.