

Virginia Department for Aging and Rehabilitative Services Community-Based Services Division

Community Rehabilitation Case Management Services Program Application

Important Information: Signed Authorization for Release of Information must accompany the CRCMS Application.

Applicant Name _____
SSN _____ **Date of Birth** _____ **Gender:** Male Female

Address _____

Phone (____) _____ **Voice** **TTY/Videophone** **Fax** **E-mail** _____

Indicate disabilities (Check all that apply):

- Arthritis Cerebral Palsy Lupus
- Multiple Sclerosis Muscular Dystrophy Spinal Cord Injury
- Traumatic Brain Injury Other (Specify) _____

Cause and/or date of onset of disabling condition _____

Person Completing Application _____

Address _____

Phone (____) _____ **Voice** **TTY/Videophone** **Fax** **E-mail** _____

Relationship to Applicant _____

Where is Applicant currently living (Check one):

- Applicant's Own Home Friend's Home Group Home
- Homeless Nursing Home Relative's Home
- Rehabilitation Facility State Psychiatric Facility Other _____

Describe specific type of services needed short-term and long-term, and how case management can assist:

Rate the Applicant's functional abilities from 1 to 5, using the scale below

1-- Totally Independent 2-- Needs Some Assistance or Supervision 3-- Needs Moderate Assistance or Supervision
4 --Needs Significant Assistance or Supervision 5-- Totally Dependent

Economic Self Sufficiency _____ Independent Living Skills _____ Language _____
Learning _____ Mobility _____ Self Direction _____ Self Care _____

Equipment used by Applicant (Check all that apply):

- Cane/Walker Computer for Communication Communication Device
- Hearing Aid Specialized equipment for bathing/showering Wheelchair
- Other (Specify) _____

Has Applicant had history of (Check all that apply):

- Substance and or alcohol abuse Aggressive behavior/outburst Mental illness

Does applicant receive (Check all that apply):

Companion Services # hours/wk _____
 Medicaid Personal Care Services # hours/wk _____
 Waiver Services (Ventilator, MR, DD, AIDS, other)
 DARS State Personal Assistance Services # hours/wk _____

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Names and phone of family members or significant others:

Name _____	Phone (____) _____
Name _____	Phone (____) _____
Name _____	Phone (____) _____

List all support services Applicant is currently receiving and contact persons:

Service _____	Contact _____	Phone (____) _____
Service _____	Contact _____	Phone (____) _____
Service _____	Contact _____	Phone (____) _____
Service _____	Contact _____	Phone (____) _____
Service _____	Contact _____	Phone (____) _____

Additional Information On Service Needs

(Check all that apply, and specify how the service will improve employability, independent living or quality of life)

- Assistive technology / other equipment (Specify) _____
- Behavioral support (Specify) _____
- Blind / vision impaired services (Specify) _____
- Deaf & hard of hearing services (Specify) _____
- Education / training (Specify) _____
- Employment / training (Specify) _____
- Entitlement programs (Specify) _____
- Financial planning (Specify) _____
- Health insurance (Specify) _____
- Home modifications (Specify) _____
- Individual / family support / respite care (Specify) _____
- Independent living skills training (Specify) _____
- Medical rehabilitation (Specify) _____
- Mental health support for individual/family (Specify) _____
- Personal assistance services (Specify) _____
- Residential support / housing (Specify) _____
- Social /recreation / leisure (Specify) _____
- Substance abuse treatment (Specify) _____
- Transportation (Specify) _____
- Other (Specify) _____

Parent or legal guardian must sign if Applicant is under age 18 or has a legal guardian

Applicant Signature _____	Date _____
Parent/Guardian _____	Sign _____ Date _____

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Authorization for Release of Information

CRCMS Applicant Name _____

I am applying to the Virginia Department for Aging and Rehabilitative Services (DRS) for the Community Rehabilitation Case Management Services (CRCMS) Program to develop an individual service plan and to assist me in accessing rehabilitative and other supportive resources I may need.

I give permission for the agencies, organizations, facilities, and individuals listed below to release medical, psychological, social, financial, and vocational information about me to DARS (or successor) in order to determine my eligibility for the CRCMS Program, or to receive such information from DARS (or successor) for the purposes of procuring or coordinating rehabilitative services for me. I understand that my permission to release this information is voluntary; however, the absence of such information may affect the determination of my eligibility for services from the CRCMS Program. All information will remain confidential according to the guidelines described above. I may revoke this permission for release of information, in writing to DARS, at any time.

The agencies and organizations included in this release of information are listed below:

- Virginia Department of Social Services Yes No
- Virginia Department for the Blind and Visually Impaired Yes No
- Virginia Department of Behavioral Health and Developmental Services Yes No
- Veterans Administration Yes No
- Virginia Department of Health Yes No
- Virginia Department of Medical Assistance Services (Medicaid) Yes No
- CRCMS Program Selection or Advisory Committee Members Yes No

Release of information includes other organizations as listed below:

Parent or legal guardian must sign if Applicant is under age 18 or has a legal guardian

Applicant Signature _____	Date _____
Parent/Guardian _____ Sign _____	Date _____