DARS
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

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Personal Assistance Services Program

Application for Services

1. Name: _____ **2**. SSN.: _____
Last First MI

3. Street Address: _____ Apt. # _____ **4**. City: _____ **5**. State: _____

6. Zip Code: _____ **7.**: Phone #:_____ **8.**: County of Residence: _____

9. Cell phone #:_____ **10**. E-mail: _____ **11**. Gender: ☐ Male ☐ Female

12. Referral Source :_____(Self, DRS, Center for Independent Living, Other)

13. Are you a veteran? ☐ YES ☐ NO

14. **Current Services** (Check if using any of these agencies **now**):

☐ Department for Aging and Rehabilitative Services
☐ Department for the Blind & Visually Impaired
☐ Center for Independent Living
☐ Community Services Board (Community Mental Health and ID Services)
☐ Department of Social Services
☐ Health Department
☐ Department for the Deaf & Hard of Hearing

15. Do you receive any of the following? **Any Medicaid Waiver such as: Developmental Disability Waiver or CCC plus Waiver**?
☐ YES ☐ NO

16. **PAS SERVICE requested** ☐ State PAS ☐ Vocational Rehabilitation PAS ☐ PAS for Persons with Brain Injury (PAS/BI)

17. **PRIMARY DISABILITY**:

☐ ALS
☐ Amputation(s)
☐ Brain Injury
☐ Traumatic
☐ Non-traumatic
☐ Cerebral Palsy
☐ Diabetes
☐ Heart/Lung Disease
☐ Lupus
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Osteoarthritis
☐ Post Polio Syndrome
☐ Rheumatoid Arthritis
☐ Seizure Disorder
☐ Spina Bifida
☐ Spinal Cord Injury
Level I, II, III_____
☐ Other (please explain):
_____
_____
_____
_____
_____
_____

18. **SECONDARY DISABILITIES** (Please List):_____
_____

19. Date of Birth: _____

20. Age when Disability Occurred: _____

21. Race:

☐ Caucasian
☐ African American
☐ Asian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Hispanic

22. ***Do you need assistance with any of the following activities?***

Personal Care (Activities of Daily Living)

- ☐ Eating
- ☐ Food Preparation
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting

Mobility Support

- ☐ Getting in and out of bed
- ☐ Moving around (inside your home)
- ☐ Mobility when leaving your residence
- ☐ Transportation

Medically Related Support

- ☐ Injections
- ☐ Taking pills
- ☐ Range of motion (ROM)**/**exercise program

23. Number of **days per week** personal care is needed: _____

24. Number of **hours per day** personal care is needed: _____

25. Who currently provides you with personal care?

- ☐ Family members
- ☐ Volunteers
- ☐ Paid individuals
- ☐ No one

26. Your **Income**: from **Employment and other sources**:

- ☐ Employment $_____
- ☐ SSI $_____
- ☐ Social Security $_____
- ☐ TANF $_____
- ☐ Other Disability Benefits $_____

27. Do you currently use **assistive technology** such as a wheelchair, walker, crutches, or a Hoyer lift?

☐ Yes ☐ No

28. If you are **employed, best time to contact you**?

☐ Before noon ☐ After noon ☐ Between 3-5 p.m.

29. What is the best method of contact

- ☐ Telephone
- ☐ Email

30. DRS Counselor's Name if you are receiving **Vocational Rehabilitation Services**

_____

31. Where do you live?

- ☐ Home or Apartment
- ☐ Home of a Relative
- ☐ Home of a Friend
- ☐ Assisted Living Facility
- ☐ Nursing Home
- ☐ Other _____

32. Signature of Applicant: _____ Date: _____