PERSONAL ASSISTANCE SERVICES PROGRAM
APPLICATION FOR SERVICE
AND STATEMENT OF UNDERSTANDING

Applicant Name _____ County Sussex

Address _____

_____

Social Security# _____

I hereby apply for participation in the Personal Assistance Program.

- ☐ I agree to the following terms and conditions in applying for such service, and by my signature, indicate that I understand and accept the responsibilities involved in my participation in the Personal Assistance Program, as detailed below:

- ☐ Personal assistance services are provided contingent upon the availability of funding and personnel to provide such services. There is no guarantee that services will be available to me at the times, or for the number of hours I request or may need.

- ☐ I understand that the services of the personal assistant are to be directed and supervised by myself, and that I am responsible to see that the services I receive are those listed in my Plan of Service.

- ☐ I agree to report to the County PASP Coordinator, or other individual designated to receive such information, any information which would change my need or eligibility for services during the course of my participation on this program.

- ☐ I agree to accept full responsibility for arrangements, including payment for any skilled nursing, therapy, or other medical care or treatment service I may need or that is ordered by a physician, or that requires the supervision of a licensed or registered professional.

- ☐ If assessed a cost share liability for the services I receive, I agree to pay this cost share amount on a monthly basis, following determination of the amount and I understand that I may be terminated from the program if I do not make such cost share payment without good cause.

- ☐ I understand that I am entitled to file a request for an Administrative Hearing of any decision with regard to eligibility determination or any other matter pertaining to my application for, or participation in, the Personal Assistance Service Program.

APPLICATION FOR SERVICE AND STATEMENT OF UNDERSTANDING

- □ I agree to attend a training program designed to enhance independent living for consumers, as a condition for participation on the program, and I understand that I may be terminated from the program if I do not attend such a program offered through the Department of Human Services, Division of Disability Services, when it is made available.

- □ I understand that information pertaining to determining eligibility and service provision under the Personal Assistance Services Program, will be shared with the Division of Disability Services, and I further understand that this information is to be used to maintain statistical records in accordance with program law, and as part of the statewide supervision of the program.

- □ I agree to abide by the guidelines, directives and procedures issued by the Personal Assistance Services Program, and to provide such information and reports as are requested by Sussex County or the New Jersey Department of Human Services, Division of Disability Services.

Signature of Applicant: _____

Date: _____

Signature of Witness: _____

Date: _____

Signature of PASP Coordinator: _____

Date: _____

Form 1

PERSONAL ASSISTANCE SERVICES PROGRAM
INCOME DECLARATION FORM

Name: _____ Social Security #: _____

Please include income amounts on yourself, spouse and/or minor children where applicable, and attach appropriate proof of income.

I. Household Size: ____ 1 ___ 2 ___ 3 ___ 4 ___ 5 (or more)

II. Earned Income: Annual Amount Received:

Employment Wages/Salary _____

Self-Employment (Net) Income _____

III.	Unearned Income	Annual Amount Received
_____	Social Security Benefits	$ _____
_____	SSI Payments	$ _____
_____	AFDC Payments	$ _____
_____	Private Disability Payments	$ _____
_____	Municipal Assistance Payments	$ _____
_____	Alimony/Child Support	$ _____
_____	Veterans Pension	$ _____
_____	Worker's Compensation	$ _____
_____	Pensions/Annuities	$ _____
_____	Unemployment Insurance	$ _____
_____	Dividends, Interest Payments	$ _____
_____	Estate/Trust Income	$ _____
_____	Rental Income or Royalties	$ _____
_____	**TOTAL ANNUAL GROSS INCOME**	$ _____

I certify that above recorded income information is accurate to the best of my knowledge, and have hereby attached required verification on the above listed income sources.

I agree to notify the PASP Coordinator of Sussex County, in writing or by telephone, if the changes in any way during my receipt of services under the Personal Assistance Services Program.

I hereby authorize the County of Sussex or Division of Disability Services to contact the source(s) of any income listed for verification of this Declaration of Income.

Signed: _____ Date: _____

Witness: _____ Date: _____

Relationship: _____

PERSONAL ASSISTANCE SERVICES PROGRAM
PHYSICIAN'S CERTIFICATION

Patient Name: _____

Nature of Disability:

_____

_____

Physician Note: The program regulations define "chronic physical disability" to mean a severe impairment of a permanent nature which so restricts a person's ability to perform essential activities of daily living that person needs assistance to maintain the person's independence and health.

Based on my knowledge of the above named patient, and his/her medical condition and cognitive abilities, I make the following determinations relative to his/her application to participate in the Personal Assistance Service Program:

___ Yes ___ No He/she is in need of assistance services because of a permanent physical disability and/or blindness.

___ Yes ___ No The patient understands the nature of his/her disability and the limitations and restrictions it imposes, and can communicate the information to others.

___ Yes ___ No The patient understands the routine medical aspects of his/her disability and could be expected to arrange for diagnosis and treatment of such conditions if/when necessary.

Other Comments/Observations/Recommendations: _____

_____

_____

Physician Signature: _____

Physician Name (Please Print): _____

Address: _____ Telephone: _____

_____

Date: _____

Form 1

PERSONAL ASSISTANCE SERVICES PROGRAM
CONSUMER CERTIFICATION SELF-CARE REQUEST FORM

Consumer Name _____ County Sussex

Please check off all self-care services that you receive and indicate who (yourself, relative or nurse**) currently performs that service(s).**

From the tasks that you currently receive, check off which task(s) you would like to include in your Plan of Service for your personal assistant to perform for you.

For each task you would like to have completed, please check in the space under "yes".

	Indicate the person who currently performs the task? Check off all that apply.			Request Completion by a Personal Assistant.	
Task Description	Self	Relative/Friend	Nurse	Yes	No
Bowel Care					
Intermittent Catherization					
Bladder Irrigation					
Ventilator Assistance					
Nail Clipping					
Trachea Care					
Skin Breakdown / Wound Care					
Tube Changes					
Assistance with Medications					
Assistance with Injections					
Glucose Monitoring					

I hereby request the ability to direct and manage my self-care services performed by my personal assistant under the Personal Assistance Services Program, and have completed a revised Consumer Plan of Services which specifies the tasks I need to have performed.

I understand that the provision of self-care services is contingent upon me being certified by a nurse, as knowledgeable of how such tasks are to be completed, as having the ability to train/instruct a personal assistant in performing such task(s) and an awareness of the consequences that may result from such arrangements. I further understand that the performance of such tasks without the required certification may jeopardize my eligibility for services under the Personal Assistance Services Program.

I further understand that the receipt of self-care services is based on the availability of a personal assistant(s) who is willing to perform the requested tasks.

Consumer Signature _____ Date _____

County Agency Signature _____ Date _____

Complete the Personal Assistance Services Program Consumer Plan of Service Form and mail that along with this information to:

Lorraine Hentz
Sussex County Division of Senior Services
Sussex County Administrative Center
One Spring Street
Newton NJ 07860