



The Arc Northern Chesapeake Region
Central Region Purchase of Care Information
REDETERMINATION FORM FY16

Please complete all sections of the form, front and back. We must have this form completed and signed in order to continue to receive services. **This form does not automatically reserve funding for you. You must contact an FSS Coordinator.**

Date: _____

Adult____ Child ____

Anne Arundel ____ Baltimore City ____ Baltimore County ____ Cecil____ Harford ____
Howard____ Other_____

Applicant Name:

FIRST MIDDLE LAST

ADDRESS CITY STATE ZIP CODE

DOB _____ Age _____ Social Security # _____

Home phone # _____

Eligibility Diagnosis: Primary _____
Secondary_____

Attach most recent disability statement if not received services with The Arc NCR over 2 years (ex: doctor letter, report from Kennedy Krieger/Mt. Washington)

Does the individual have a Service Coordinator? Yes No

Service Coordinator _____ Phone number _____

Other Resources Approved:

With whom does the individual live? Parents Mother Father Relative
Foster care Guardian Self

Parent/guardian/care provider's name:

Home phone _____ Cell phone _____ Work phone _____

Email address _____ May we send information via email?
 Yes No

Emergency Contact

Name _____ Phone # _____

Address _____ Relationship _____

Where does the individual go during the day?

Name of school/agency/program/job:

INCOME INFORMATION:

PART I: If the individual to be cared for is under the of age 18, please CIRCLE the gross income of all persons living in the home including the individual and the source of income that apply:

Wages or Salary; Social Security Income; Survival Benefits, Disability; Unemployment Compensation; Child Support, Alimony; Public Assistance; Other (please specify) _____

If the gross income has changed in the past year, please circle number of household and annual income below.

HUD Designated Income Levels FY2013								
Income Limits								
	<u>1</u> <u>Person</u>	<u>2</u> <u>Persons</u>	<u>3</u> <u>Persons</u>	<u>4</u> <u>Persons</u>	<u>5</u> <u>Persons</u>	<u>6</u> <u>Persons</u>	<u>7</u> <u>Persons</u>	<u>8</u> <u>Persons</u>
Extremely Low Income	\$ 18,000	\$ 20,600	\$ 23,150	\$ 25,700	\$ 27,800	\$ 29,850	\$ 31,900	\$ 33,950
Very Low Income	\$ 30,000	\$ 34,250	\$ 38,550	\$ 42,800	\$ 46,250	\$ 49,650	\$ 53,100	\$ 56,500
Low Income	\$ 45,100	\$ 51,550	\$ 58,000	\$ 64,400	\$ 69,600	\$ 74,750	\$ 79,900	\$ 85,050

PART II: If the individual to be cared for is age 18 or above, please CIRCLE the gross income of the individual and the source of income that apply:

Wages or Salary; Social Security Income; Survival Benefits, Disability; Unemployment Compensation; Alimony; Public Assistance; Other (please specify) _____

If the gross income has changed in the past year, please circle number of household and annual income below.

HUD Designated Income Levels FY2013								
Income Limits								
	<u>1</u> Person	<u>2</u> Persons	<u>3</u> Persons	<u>4</u> Persons	<u>5</u> Persons	<u>6</u> Persons	<u>7</u> Persons	<u>8</u> Persons
Extremely Low Income	\$ 18,000	\$ 20,600	\$ 23,150	\$ 25,700	\$ 27,800	\$ 29,850	\$ 31,900	\$ 33,950
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PART III: If the individual lives in a foster care home, write the name of the foster care agency, case worker and telephone number.

NAME OF AGENCY	CASE WORKER	PHONE NUMBER / EXT.

* I certify that the above information is accurate.

 Print Name Date Applicant Signature (if applicable)

 Print Name Date Legal Guardian Signature (if applicable)

 Print Name Date Authorized agent (if applicable) Relationship

Signed Permission for Obtaining or Releasing Information

I, _____, hereby give my permission to The Arc Northern Chesapeake Region to

Obtain Information from _____

Disclose Information to _____

Pertaining to the following:

I understand that the information shared by The Arc Northern Chesapeake Region shall remain confidential and may not be re-disclosed to a third party. This permission shall take effect from the date of this authorization until the following date: _____. If no date is indicated, this permission expires automatically at the end of one year. I understand that I may revoke this permission at any time.

I have read this form and decline to have The Arc NCR obtain/release information concerning my Child Self.

Signature Date

Parent/Guardian Signature, if applicable Date

Authorized Representative Signature Date

Please return this form to:
The Arc Northern Chesapeake Region
ATTN: Family Support Services
4513 Philadelphia Road
Aberdeen, MD 21001
Fax: 410-893-3909
Email: fss@arcncr.org