

SECTION 2: EMPLOYMENT STATUS

Please check only **one** of the following four employment priority levels. Be sure to answer **all** the questions under the employment priority level you have chosen and attach to this application the appropriate documentation requested for the employment priority you have chosen, if required.

1. COMPETITIVELY EMPLOYED

a) Please check the **one** statement that **best** describes your type of employment:

- Work outside my home for an employer
- Work outside and inside my home for an employer
- Work inside my home for an employer
- Self-employed with my own business-work performed outside of my home
- Self-employed with my own business-work performed outside and inside of my home
- Self-employed with my own business-work performed inside of my home.....

b) How many hours per week do you work? _____
(If hours vary from week to week, provide a typical or average number of hours worked per week. Include only those hours actually worked. For example, if you run an answering service and are on call, just include the time you are actually performing the work.)

c) What is your hourly wage? \$ _____
(If you are paid a weekly or monthly flat fee, divide the total hours worked in the week or month into the fee paid to determine your hourly wage. If you are self-employed and paid various fees, take an average month's income and divide by the total hours worked for that month to reach an average hourly wage.)

d) Please provide a description of your job duties or the type of work you perform. If you are self-employed and paid by the assignment, include information on the typical number of assignments completed each month and the fee typically paid per assignment.

You need to document your choice of competitive employment. If you receive a weekly/bi-weekly/monthly paycheck for the work you perform, please include a copy of your most recent paycheck stub with your application. If you are self-employed, i.e., an independent contractor, provide copies of invoices or bills you provided to your clients for the work performed in the past three months and copies of any payments received during the past three months for these invoices or other invoices. If you have not performed any work assignments in the past three months, you need to provide justification as to why you feel you should still be considered as competitively employed. **For self-employment not earning competitive wages, you also need to provide an outline of a business plan with measurable benchmarks for meeting certain goals within your business, i.e. 1st year goal, 2nd year goal, etc., for consideration of this category.**

SECTION 2: EMPLOYMENT STATUS (Con't)

2. ACTIVELY SEEKING EMPLOYMENT

Please provide a description of your job seeking activities. Be very specific as to what you are doing. Your information should include, but may not be limited to: a list of employers you have interviewed with and on what dates; how many times a week do you mail out your resumé; what types of resources do you use to locate employment (job clubs, newspaper ads, etc.); if you work with a job club; how often does it meet.

To document your choice of seeking employment, please include a copy of the current resumé you are using in your job search with your application. **(Resume is required for this category)**

3. ACTIVELY INVOLVED IN FORMAL TRAINING

- a) What is the name of the school you are attending? _____
- b) What is your major course of study? _____
- c) When do you expect your training to be completed? _____
- d) Are you working with BVR/BSVI? Yes No

To document your participation in training, please provide a copy of a registration showing you are registered for classes, or a copy of a receipt or a copy of a paid tuition bill and/or a copy of a recent grade report.

****4 NOT COMPETITIVELY EMPLOYED OR ENGAGED IN AN ACTIVITY TO LEAD TO COMPETITIVE EMPLOYMENT AT THIS TIME** **This Category is CLOSED TO NEW APPLICANTS**

SECTION 3: ASSESSMENT OF PERSONAL ASSISTANCE NEEDED

1. DESIGNATE **ALL** AREAS IN WHICH YOU REQUIRE ASSISTANCE even if you will not use hours from the PCA Program to assist with this area.

- | | | | | | |
|-----------------------------|--------------------------|--------------------------------------|--------------------------|-------------------------------|--------------------------|
| Ambulating | <input type="checkbox"/> | Driver services | <input type="checkbox"/> | Reading services | <input type="checkbox"/> |
| Bathing | <input type="checkbox"/> | Fine motor activities | <input type="checkbox"/> | Record keeping and/or | |
| Bladder care | <input type="checkbox"/> | Household chores | <input type="checkbox"/> | correspondence | <input type="checkbox"/> |
| Bowel program | <input type="checkbox"/> | Meal preparation/set-up/feeding..... | <input type="checkbox"/> | Toileting | <input type="checkbox"/> |
| Clothing maintenance | <input type="checkbox"/> | Medication | <input type="checkbox"/> | Transfers/repositioning | <input type="checkbox"/> |
| Communication services..... | <input type="checkbox"/> | Personal grooming | <input type="checkbox"/> | Ventilator maintenance | <input type="checkbox"/> |
| Dressing | <input type="checkbox"/> | Physical therapy exercises..... | <input type="checkbox"/> | | |

2. DESIGNATE WHICH ASSISTANCE DEVICES YOU USE: (Check **all** that apply.)

- | | | | | | |
|----------------------------|--------------------------|-------------------------|--------------------------|--------------------------------|--------------------------|
| Adaptive equipment..... | <input type="checkbox"/> | Hearing aid | <input type="checkbox"/> | Supervision of activities | |
| Artificial limb | <input type="checkbox"/> | Lift..... | <input type="checkbox"/> | of daily living required | <input type="checkbox"/> |
| Braces | <input type="checkbox"/> | Manual wheelchair | <input type="checkbox"/> | Three-wheel scooter | <input type="checkbox"/> |
| Cane/crutches/walker | <input type="checkbox"/> | Power wheelchair | <input type="checkbox"/> | Visual aides | <input type="checkbox"/> |
| Communication devices..... | <input type="checkbox"/> | Respiration aids | <input type="checkbox"/> | | |
| Other | <input type="checkbox"/> | | | | |

3. SOURCES OF OTHER PERSONAL ASSISTANCE SERVICES: (Check **all** that apply. You **must** also provide the number of hours per week of assistance. If the hours vary, provide the best estimate of the average number of hours per week you receive assistance. **Do not** check Medicaid or Medicare if you only receive medical coverage through these sources and do not receive personal assistance services.)

BVR/BSVI.....	<input type="checkbox"/>	Number of hours per week	_____
Family/friends	<input type="checkbox"/>	Number of hours per week	_____
Individual Options Waiver (Waiver VI through MR/DD)	<input type="checkbox"/>	Number of hours per week	_____
Medicaid Core (through Job & Family Services)	<input type="checkbox"/>	Number of hours per week	_____
Medicaid Core Plus (through Job & Family Services)	<input type="checkbox"/>	Number of hours per week	_____
Medicare.....	<input type="checkbox"/>	Number of hours per week	_____
OBRA Waiver	<input type="checkbox"/>	Number of hours per week	_____
Ohio Home Care Waiver (through Job & Family Services)	<input type="checkbox"/>	Number of hours per week	_____
PASSPORT Waiver (through Dept of Aging)	<input type="checkbox"/>	Number of hours per week	_____
Private Insurance.....	<input type="checkbox"/>	Number of hours per week	_____
Private Pay (Paid for by you and not reimbursed).....	<input type="checkbox"/>	Number of hours per week	_____
Supported Living Program (through MR/DD)	<input type="checkbox"/>	Number of hours per week	_____
Other: (List below any other source(s) not identified above and the		Number of hours per week	_____
_____		Number of hours per week	_____
_____		Number of hours per week	_____

4. Have you independently hired assistants in the past? Yes No
5. Will you need assistance in hiring assistants? Yes No
6. How many hours per week of assistance are you requesting for the PCA Program? _____
7. When would you need services from this program to begin? _____

My signature below indicates that I am applying for the Personal Care Assistance Program and that I understand the information given will be used by the Rehabilitation Services Commission (OOD) and by other agencies working with OOD in providing services to me. I understand that the services of this program are provided without discrimination. In addition, I understand that I should direct any comments, questions, or complaints about my application or about services under the program to the agency or organization through which services are coordinated in my community or by contacting the Program Coordinator at OOD directly.

Applicant's signature  _____

All questions must be answered as completely as possible for this application to be considered. If additional space is required, please feel free to attach a separate sheet of paper.

OOD does not discriminate on the basis of age, color, national origin, race, sex, or type of disability.