VERMONT

201G-ADL (CORR-Incoming in OnBase)

Department for Children and Families
Economic Services Division
280 State Drive
Waterbury, VT 05671-1020

Agency of Human Services

[fax] 802-241-0460
[toll free] 800-479-6151

Emergency Housing ADL Waiver Request Form

If the Economic Services Division (ESD) is currently housing you under the disability prong of rule EH-720 and you or a household member has a disability that significantly impairs your activities of daily living (ADL), or you or a household member is eligible for: Choices for Care; development services; CRT; brain injury program; or attendant services, you may request that the Deputy Commissioner of ESD waive the 84-day maximum. If approved, your emergency housing will be extended up to 30 days at a time.

In conjunction with this waiver request, you agree to be connected by ESD to the nurse coordinator who covers the region of the state from the Department of Disabilities, Aging and Independent Living (DAIL) or with the Vermont Chronic Care Initiative, whichever is more appropriate.

Applicant Name:_____ DOB:_____ Last 4 SSN:_____

Activities of Daily Living (ADL) are "dressing and undressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility in and around the home, and eating." To receive a waiver of the 84-day maximum, you or a household member must have a disability that significantly impairs your or their ability to perform one or more of these activities independently. Examples of significant impairments include: needing assistance with dressing; bathing; getting in and out of bed; getting on and off the toilet; eating; transferring in and out of a wheelchair; use of an oxygen machine; or power wheelchair; etc.

Please explain how the disability significantly impairs one or more of these activities (This section may be filled out by the applicant, housing case manager, legal representative, or other personal representative):

_____

_____

_____

_____

Or please confirm you or a household member is eligible for: Choices for Care; development services; CRT; brain injury program; or attendant services.

☐ Choices for Care ☐ Brain Injury Program ☐ CRT

☐ Developmental Services ☐ Attendant Services

Printed name of person completing this form: Relationship to the Applicant:	Phone number: Name of business (if applicable):
Signature of person completing this form:	Date:

Please complete the back of this form

Initial 09/2021

Emergency Housing--Disability/Activities of Daily Living

Authorization to Release Information

Name of Household Member Requesting Accommodation:	Date of Birth
Name of Legal Representative (if applicable)	

I, or my legal representative, authorize:

the Economic Services Division Benefit Program Specialist

to provide the nurse coordinator from the Department of Disabilities, Aging and Independent Living (DAIL) or a referral for case management services to the Vermont Chronic Care Initiative with the information that was provided on the Emergency Housing Extension Waiver Request form for Disability/Activities of Daily Living, including, when applicable, drug and alcohol treatment records.

I understand that ESD will provide this information for the purpose of: connecting me with the services that can be provided by either the DAIL nurse coordinator or Vermont Chronic Care Initiative.

By signing this form, I understand:

- The reason(s) I am being asked to release information.
- Signing this authorization is voluntary. If I choose not to sign, I can still apply for Emergency Housing, but my request for an extension of emergency housing may be denied as ESD will be unable to link me to the DAIL nurse coordinator or the Vermont Chronic Care Initiative for additional supports.
- While the Vermont Department for Children and Families takes every precaution to protect my health information, once it is disclosed pursuant to this authorization, it may be subject to redisclosure.
- My drug and alcohol treatment records are protected by Federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.
- I may revoke this authorization at any time by contacting the Benefits Service Center at 1-800-479-6151 except to the extent that it has been acted upon.
- If I do not revoke or update this authorization, it will be in effect as long as I am receiving General Assistance Emergency Housing services.
- I will be given a copy of this form.
- All items on this form and my questions about this form have been answered.

Signature of Household Member Requesting Extension of Emergency Housing or Legal Representative:	Date:
If you are the personal representative, print name and contact information:	Description of authority to sign on behalf of household member requesting accommodation: