Michigan Centers for Independent Living
Department of Health & Human Services - Michigan Rehabilitation Services

Personal Assistance Services Reimbursement for Employment Program

Eligibility Statement and Declaration

1. I am a person with a disability who is employed an average of at least 24 hours per week, earning at least the current minimum wage. Or, I have a documented offer of such employment.
2. I require at least five hours of personal assistance services per week to perform routine daily living activities because of limitations of physical functioning.
3. I require these personal assistant services to maintain or enter employment.
4. My household income minus my financial responsibility for personal assistance (PA) is not adequate to pay for the PA services I require to obtain/maintain employment.
5. I do not have adequate liquid and/or readily convertible assets to cover my ongoing PA needs.
6. I understand and accept the responsibility to hire and supervise my personal assistants, and manage all aspects of their employment. I understand that I am responsible for paying all social security, Medicare, federal/state unemployment, and complying with all applicable federal and state employment laws. I assume any liability for my personal assistants, and will carry appropriate liability insurance including Workers Compensation.
7. I understand that any personal assistants I employ cannot be considered an employee, agent, or legal representative of any Center for Independent Living for any purpose.
8. I will submit copies of my Federal tax return with all schedules, copies of W2 and 1099 forms, and proof of my employment each year to maintain my eligibility. (Proof of employment can be a pay stub or accounting statement for self-employment.)

By signing this eligibility statement and declaration, I declare that the information contained is true, correct, and complete to the best of my knowledge. I understand that the burden of proof of my eligibility for this program rests with me, and that additional documentation may be required to substantiate my eligibility. **I will notify the designated CIL program representative within one month when changes in my circumstances occur that may affect my eligibility *including any increase or decrease of $5,000 or more in annual income.*** I recognize that my failure to report such changes could lead to my termination from the program. If the recertification process determines that the reimbursement amount I am eligible for decreased significantly in the past year and I did not report the change in circumstances that caused the decrease, I will be required to reimburse the overpayment to the program. This amount can be subtracted from future reimbursements. I also acknowledge that funds from this program cannot be used to pay an immediate family member living in my household unless specifically qualified. **I understand that if false information is given, this agreement may be terminated immediately upon discovery of such information.** Any changes to this agreement must be made in writing.

I have received a copy of the PASREP Policy Manual, read it, understand it and agree to comply with the policies contained in the manual.

_____ _____

Signature of Participant Date Signed (revised 3/1/09)

Applicant Information

1. _____ 2._____ 3. Gender: M F
Name Date of Birth

4. _____ _____ _____
Street Address City Zip Code County of residence

5. _____ _____ _____
Home Phone Work Phone Email address

6. _____ _____
Primary Disability Date of Onset

7. _____ 8._____
Secondary Disability (if applicable) Ethnicity (optional)

9. _____ 10. _____
Marital Status Name of spouse/significant other

11. Is spouse/significant other employed? Yes No If yes, complete "other" column of "Income Information" on page 4.

12. Dependents living in your household:

Name	Age	Relationship

13. Prior to employment did you have Medicaid without a spend down? Y N

14. Are you currently on Freedom to Work? Y N Don't Know

15. How long have you been using PA services on a regular basis? _____

16. During the last year, how many hours per month (average) have you employed a PA to assist you?_____

17. In addition to paid time, how many hours per month have family or co-workers assisted you?_____

18. What are the current costs per hour of PA services in your community?
Private Individual: $_____/hour Agency: $_____/hour

19. If you employ your PA's what is your Federal Employer Identification Number (FEIN)?_____

20. If you do not employ your own PA's what is the name of the agency that you use?_____

Employment Information

21. _____
Occupation/Job

22. _____
Employer

23. _____
Address City Zip Code

24. _____ 25. _____
Your Title Start Date

26. _____ 27. _____
Supervisor Supervisor's Phone

28. Average number of hours worked per week: _____

29. Rate of pay: $_____ Hourly/weekly/monthly/annual (circle applicable)

Home-Based and/or Self Employment

30. Please describe your employment: _____
_____

31. How long have you been self-employed? _____

32. Average number of hours worked weekly: _____

33. Average number of hours worked annually (for seasonal employment): _____

34. Average monthly income produced: $_____

Additional Reporting/Qualifying Requirements for Self-Employment

*Copies of quarterly estimated tax payments.
* If the amount of hours average less than 24 hours per week, please provide explanation.
*Average weekly income must equal at least 24 hours multiplied by the current minimum wage in order to be qualified for this program.

Comments: _____
_____
_____

Income Information

	Self		Other		Total Household
35. ***Annual gross earnings***	_____	+	_____	=	_____

36. Additional income: SSI/SSDI _____, Interest/Dividends_____,
Social Security for dependent children_____, Child Support_____, _____
Other_____

37. Add lines 35 and 36. _____

38. ***300% of current federal poverty level*** _____
See insert with application for current year's level.

39. ***Baseline income to determine eligibility***-Subtract line 38 from 37. _____
If less than 0, enter 0.

40. ***Participant's annual financial responsibility for PAS*** _____
(15 % of income above the 300% of poverty level) Multiply line 39 by .15

41. ***Participant's monthly financial responsibility***-Divide line 40 by 12. _____

Summary of PA Need and Costs

42. ***Number of hours of PA/month (from Self Assessment Form)*** _____

43. ***Hourly rate that you pay for your PA services*** _____

44. ***Monthly PA cost-*** multiply line 42 by line 43. _____

45. ***Include Employer Taxes-***If you pay these taxes as a household employer, otherwise leave blank. Ask your CIL representative for more information. _____

46. ***Monthly PA cost plus taxes paid***-Add lines 44 and 45. _____

47. ***PA cost paid or reimbursed from other sources e.g. FIA*** _____
Specify _____

48. ***Unmet monthly PA costs-*** subtract line 47 from line 46. _____

Reimbursement Eligibility

49. ***Participant's monthly responsibility*** -see amount on line 41 above.
(Please round to whole dollar amount) _____

50. ***Eligible monthly reimbursement or $1000, whichever is less.*** _____
-subtract line 49 from line 48. (Please round to whole dollar amount)