James Patrick – Personal Attendant Services Program

Dear Program Applicant:

Thank you for your interest in the **James Patrick – Personal Assistance Services Program (JP-PAS)**. The program is designed for working persons with chronic disabilities who need a personal care attendant (PCA) to help them maintain employment. Program participants can receive up to $2,160 per month for reimbursement of actual PAS expenses.

Persons who wish to apply must meet all of the following eligibility criteria:

- Must be a person with a disability who requires personal assistance service (PAS) for support for at least two activities of daily living as determined in writing by a physician or psychiatrist. Activities of daily living means functions and tasks for self-care including ambulation, bathing, dressing, eating, grooming, and toileting (F.S. 429.02).
- Must be at least 18 years of age.
- Must be a U.S. citizen and Florida resident or, if a non-U.S. citizen, must be a legal permanent resident of the state.
- Must be able to acquire and manage a personal care attendant.
- Must be employed, earning an individual earned income of at least the federal poverty level for a household of one but less than $200,000.
- Must not receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) cash benefits.
- Must not be receiving Medicaid Home and Community Based Services.

If you meet the eligibility requirements, please complete the enclosed **Program Application** and **Diagnosis Verification Form** and submit with all required documentation as listed below:

- Proof of age and U.S. Citizenship or lawful Permanent Resident status
  - U.S. Citizenship: original or certified U.S. birth certificate, valid U.S. passport, or Certificate of Naturalization
  - Permanent Resident: I-551 “Green Card”

- Proof of Florida residency - must provide two
  - Florida Driver's License or Florida State Identification Card
  - Florida Voter Registration or Florida Vehicle Registration
  - Transcripts from a Florida college for a degree earned within the last 12 months
  - Utility bills, cable bills, or a land line telephone bill or other documentation

- Proof of Employment
  - Copy of Pay Stubs for the past 30 days of employment
  - Letter of Intent to Hire
  - If self-employed, please provide 1040SE with Schedule C, F or SE, federal income tax return, bookkeeping records, bank statements, profit and loss statement, etc.

- Copy of your most recent federal income tax return and W2/1099 etc. If a joint tax return was filed, please also provide the W2 for the spouse.

- Proof that you are not receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). This can be obtained online by visiting: https://www.ssa.gov/myaccount/ OR by requesting A Benefits Planning Query (BPQY) which can obtained from the Social Security Administration.

Space in the JP-PAS program is limited, and applications are accepted on a first come, first served basis. Therefore, it is strongly recommended applicants submit all required forms and documentations as soon as possible to:

James Patrick-PAS Program
c/o Florida Association of Centers for Independent Living
325 John Knox Road, Building C, Suite 132
Tallahassee, FL 32303

Completed Application Packages will be reviewed for consideration in the order in which they were received. Applicants will receive a letter noting the status of the application and the current program availability within four weeks after all Application Package materials are received. Applicants will be notified via e-mail or by phone if the application package is incomplete. Application Packages that remain incomplete for a period of 30 days will be denied.

Sincerely,

Jane Johnson

Jane Johnson
Chief Executive Officer

Florida Association of Centers for Independent Living
James Patrick – Personal Attendant Services Program
Application

Personal Information

Last Name	First Name	Middle
Address		
City	County	Zip
Home Phone	Cell Phone	Work Phone
Email Address	Social Security #	Date of Birth

Employment Information

Employer	Supervisor Name	Employer Phone
Employer Address		
Employer City	Employer State	Employer zip
Position	Date of Hire	Annual Gross Earned Income
Work Email		

Additional Information

	Yes/No
Are you currently a Full Time Florida resident?	
Are you a US Citizen or Legal Permanent Resident?	
Do you receive SSI or SSDI?	
Are you enrolled in a Medicaid Home and Community Based services waiver?	
Do you require a Personal Care Attendant for assistance with at least 2 daily tasks such as ambulation or transfer, bathing, dressing, eating, grooming, or toileting?	

Florida Association of Centers for Independent Living
James Patrick – Personal Attendant Services Program
Activities of Daily Living Checklist

Complete all that apply:

	Needs Daily Help	Needs Some Help (How often)	Needs No Help
Bathing			
Grooming			
Shave			
Oral care			
Make up			
Hair styling			
Toileting			
Urinary			
Stool			
Dressing			
Eating			
Prepare meal			
Cut up food			
Feed self			
Ambulation			
Getting out of bed			
Getting out of chair			
Transferring to bed/chair			

MOBILITY DEVICES (Check all that apply):

Manual wheelchair	
Power wheelchair/scooter	
Walker	
Forearm crutches	
Crutches	
Other - Please describe:	

Applicant's Signature **Date**

Optional Information

The information you provide is optional and only used to survey the population for which the program serves. It is not required or used to determine eligibility in the program.

Highest Level of Education		Other Skills or Professional Certifications
	Below High School	
	High School	
	Vocational School	
	Associates Degree	
	Bachelor's Degree	
	Master's Degree	
	Other:	

	Gender		Ethnicity
	Male		White/Caucasian
	Female		Black/African American
	Ethnicity		American Indian/Alaskan Native
	Hispanic/Latino		Asian
	NOT Hispanic/Latino		Other ________________________

How did you find out about the program?

I am aware that any omissions, misstatements, or misrepresentations above may disqualify me for consideration and, if I am approved, may be grounds for termination from the program at a later date. I understand that any information I give may be investigated as allowed by law. I consent to the release of this disclosed information and information from employers, schools, and other individuals and organizations to the Florida Association of Centers for Independent Living (FACIL) and other authorized contracted employees/agents of FACIL to administer this program. This consent shall continue to be effective during my participation in the program. I understand that applications submitted are public records. I certify that to the best of my knowledge and belief all of the statements contained herein and on any attachments are true, correct, complete, and made in good faith.

Applicant's Signature **Date**

Florida Association of Centers for Independent Living
James Patrick – Personal Attendant Services Program
Diagnosis Verification Form

The person listed below has applied to take part in the James Patrick Personal Attendant Services program (JP-PAS). In 2008, the Florida Legislature established JP-PAS which allows working Florida residents with documented severe and chronic disabilities to receive a monthly stipend specifically to maintain a Personal Care Attendant (PCA) to assist them with activities of daily living.

TO BE COMPLETED BY JP-PAS PARTICIPANT

Name: ______________________________

Address: ______________________________

City/Zip: ______________________________

Social Security #: ______________________________

Date of Birth: ______________________________

I authorize the individual or organization listed below to disclose only the necessary information relevant to my disability history as it relates to eligibility for the James Patrick Personal Attendant Services (JP-PAS) program as outlined below to the Florida Association of Centers for Independent Living (FACIL). I also understand that I may inspect a copy of the information to be used or disclosed as provided in CFR 164.524. I understand I have the right to revoke this authorization at any time by writing to the healthcare provider listed below, except to the extent that action has already been taken based on this authorization. I also understand this authorization is only good for one year from the date of my signature below.

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Applicant's Signature **Date**

TO BE COMPLETED BY MEDICAL STAFF

Medical Diagnosis: ______________________________

I attest that the applicant named above has a severe and chronic disability and requires personal assistance services (PAS) for at least two activities of daily living as defined in F.S 429.02: functions and tasks for self-care including ambulation, bathing, dressing, eating, grooming, or toileting.

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Physician/Psychiatrist Signature **Date**

Medical Facility/Provider Name: ______________________________

Address: ______________________________

City/Zip: ______________________________

Phone #: ______________________________

Fax #: ______________________________

Once form is completed return to:

Mail to:	*Fax to:*	*Email to:*
325 John Knox Rd, Bldg C, Ste 132, Tallahassee, FL 32303	*850-575-6093*	*jppas@floridacils.org*