Dear 2024 Applicant,

Enclosed is the application for building a handicap ramp that you requested from dis***Ability*** Connections. We ask that you read and complete the entire application and return it to us with the required documents. Applications that are complete and approved will be put on a first come, first served build calendar. You will be notified upon application approval, but please keep in mind that due to limited volunteer time and weather restrictions we cannot provide an exact build date. Applications will not be considered complete and put on the build calendar until all required information is received.

Please note that there is a co-pay of 25% of the material costs for this ramp. Co-pay amounts are not known until an assessment of the property is made, drawings are complete and materials are ordered. As you can imagine, each ramp is different and built to the needs of the property that it will serve. With this in mind, we can provide only an estimated amount of what a co-pay will be using the cost of an average sized ramp. Most ramps are 20 to 23 feet in length with materials averaging approximately $1,700.00. The co-pay on this amount would be $425.00. *Please note that this is an ESTIMATE ONLY.*

We understand that this amount could be a hardship to some individuals. In the event that full payment cannot be made upon completion of the ramp we will work with you to create a payment schedule that will accommodate your budget.

Application may be submitted via email to the address below or via mail/delivery to 409 Linden Ave, Jackson MI 49203. If you have any questions or concerns please feel free to contact me.

Sincerely,

Danielle C. Lynch
Director of Operations
(517) 998-3081
danielle@disabilityconnect.org

Ramp Assistance Criteria

1. User must have a physical disability that requires a ramp to enter and exit the residence.
2. The residence must be located in Jackson County.
3. Household income must meet low-income requirements (185% of poverty) as established by the federal government.
4. User or a family member must own the residence; have a long-term lease (minimum of 5 years) or a history of long-term occupancy in the residence to which the ramp is intended. If the property is not owned by the user or family member, prior written approval must be obtained from the property owner or landlord stating a ramp may be built on the premises.
5. The applicant must sign the Release of Information and Disclaimer forms in order to be eligible for project participation.
6. Applicant much pay the 25% materials co-pay or make arrangements for a payment plan within 30 days of billing.
7. The property owner must agree with the recommendations of the Ramp Project Building Committee as to the design and placement of the ramp.
8. Show removal and cleaning are the responsibility of the user.
9. The user agrees that the ramp is received in good condition.
10. The applicant/individual using the ramp assumes full responsibility and agrees to indemnify (holds harmless) disAbility Connections, Inc., and its directors, officers, employees, volunteers and agents from any and all liability arising in any way out of the use of the ramp.

By signing this form, I agree that I have read, understand and will comply with the ramp assistance criteria.

Signature	Date
Parent/Guardian Signature (if applicable)	Date
Witness Signature	Date

Revised: 1/2/2024

2024 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	7,530.00	11,295.00	15,060.00	18,825.00	19,578.00	20,029.80	20,331.00	20,782.80	22,590.00	26,355.00	27,108.00	27,861.00
2	10,220.00	15,330.00	20,440.00	25,550.00	26,572.00	27,185.20	27,594.00	28,207.20	30,660.00	35,770.00	36,792.00	37,814.00
3	12,910.00	19,365.00	25,820.00	32,275.00	33,566.00	34,340.60	34,857.00	35,631.60	38,730.00	45,185.00	46,476.00	47,767.00
4	15,600.00	23,400.00	31,200.00	39,000.00	40,560.00	41,496.00	42,120.00	43,056.00	46,800.00	54,600.00	56,160.00	57,720.00
5	18,290.00	27,435.00	36,580.00	45,725.00	47,554.00	48,651.40	49,383.00	50,480.40	54,870.00	64,015.00	65,844.00	67,673.00
6	20,980.00	31,470.00	41,960.00	52,450.00	54,548.00	55,806.80	56,646.00	57,904.80	62,940.00	73,430.00	75,528.00	77,626.00
7	23,670.00	35,505.00	47,340.00	59,175.00	61,542.00	62,962.20	63,909.00	65,329.20	71,010.00	82,845.00	85,212.00	87,579.00
8	26,360.00	39,540.00	52,720.00	65,900.00	68,536.00	70,117.60	71,172.00	72,753.60	79,080.00	92,260.00	94,896.00	97,532.00
9	29,050.00	43,575.00	58,100.00	72,625.00	75,530.00	77,273.00	78,435.00	80,178.00	87,150.00	101,675.00	104,580.00	107,485.00
10	31,740.00	47,610.00	63,480.00	79,350.00	82,524.00	84,428.40	85,698.00	87,602.40	95,220.00	111,090.00	114,264.00	117,438.00
11	34,430.00	51,645.00	68,860.00	86,075.00	89,518.00	91,583.80	92,961.00	95,026.80	103,290.00	120,505.00	123,948.00	127,391.00
12	37,120.00	55,680.00	74,240.00	92,800.00	96,512.00	98,739.20	100,224.00	102,451.20	111,360.00	129,920.00	133,632.00	137,344.00
13	39,810.00	59,715.00	79,620.00	99,525.00	103,506.00	105,894.60	107,487.00	109,875.60	119,430.00	139,335.00	143,316.00	147,297.00
14	42,500.00	63,750.00	85,000.00	106,250.00	110,500.00	113,050.00	114,750.00	117,300.00	127,500.00	148,750.00	153,000.00	157,250.00

Dollars Per Month

sehold/Family S	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	$628	$941	$1,255	$1,569	$1,632	$1,669	$1,694	$1,732	$1,883	$2,196	$2,259	$2,322
2	$852	$1,278	$1,703	$2,129	$2,214	$2,265	$2,300	$2,351	$2,555	$2,981	$3,066	$3,151
3	$1,076	$1,614	$2,152	$2,690	$2,797	$2,862	$2,905	$2,969	$3,228	$3,765	$3,873	$3,981
4	$1,300	$1,950	$2,600	$3,250	$3,380	$3,458	$3,510	$3,588	$3,900	$4,550	$4,680	$4,810
5	$1,524	$2,286	$3,048	$3,810	$3,963	$4,054	$4,115	$4,207	$4,573	$5,335	$5,487	$5,639
6	$1,748	$2,623	$3,497	$4,371	$4,546	$4,651	$4,721	$4,825	$5,245	$6,119	$6,294	$6,469
7	$1,973	$2,959	$3,945	$4,931	$5,129	$5,247	$5,326	$5,444	$5,918	$6,904	$7,101	$7,298
8	$2,197	$3,295	$4,393	$5,492	$5,711	$5,843	$5,931	$6,063	$6,590	$7,688	$7,908	$8,128
9	$2,421	$3,631	$4,842	$6,052	$6,294	$6,439	$6,536	$6,682	$7,263	$8,473	$8,715	$8,957
10	$2,645	$3,968	$5,290	$6,613	$6,877	$7,036	$7,142	$7,300	$7,935	$9,258	$9,522	$9,787
11	$2,869	$4,304	$5,738	$7,173	$7,460	$7,632	$7,747	$7,919	$8,608	$10,042	$10,329	$10,616
12	$3,093	$4,640	$6,187	$7,733	$8,043	$8,228	$8,352	$8,538	$9,280	$10,827	$11,136	$11,445
13	$3,318	$4,976	$6,635	$8,294	$8,626	$8,825	$8,957	$9,156	$9,953	$11,611	$11,943	$12,275
14	$3,542	$5,313	$7,083	$8,854	$9,208	$9,421	$9,563	$9,775	$10,625	$12,396	$12,750	$13,104

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Customer Rights, Responsibilities and Appeal Process

Your Customer Rights

- You have the right to request services
- You have the right to expect that all information pertaining to you will be kept confidential except where permission has been obtained
- You have the right to be treated with dignity and respect
- You have the right not to be discriminated against
- You have the right to have reasonable accommodations to help you be successful
- You have the right to accept or refuse information, referrals and/or services if you are your own legal decision maker
- You have the right to withdraw from services at anytime
- You have the right to review your file at any time
- You have the right to make changes to your Independent Living Plan as needs change

Your Customer Responsibilities

- Treat other customers and staff with dignity and respect
- Provide updated information regarding address, phone number, and other important contact information
- Take an active part in developing, planning and reviewing services, when possible

Customer Appeal Process

1. Initial discussion between customer and supervisor to determine if remedy can be implemented
2. Discussion between customer and Executive Director
3. In the event the customer does not feel satisfied with the results of their discussion with the Executive Director, a member of the Executive Committee of the Board of Director's will be notified and an appoint set between the board members and customer.
4. If customer does not feel satisfied with the results of their discussion with the Executive Committee, then the customer may contact the Client Assistance Program (CAP) at 800-292-5896

While we prefer that the appeal process be followed in the steps outlined, it is understood that the customer has the right to contact the Client Assistance Program at any point during his/her involvement with dis***Ability*** Connections.

Services available at dis*Ability* Connections

- Equipment Loan Closet
- Fix-dis Equipment Repair
- Parent Education & Resources
- Nursing Facility Transition
- Independent Living Supports
- Youth Assessment/ Training
- Ramp Building Program
- Respite Care Program
- Information & Referral
- Social & Recreational Groups/Programs
- Self-Advocacy Involvement
- Volunteer Opportunities

Your Rights.

When you apply for or receive vocational rehabilitation services, you have the right to:

- A written application for services
- A complete eligibility evaluation
- A written eligibility decision within 60 days
- A written plan within 90 days
- An annual plan review
- Accommodations for disability
- A copy of your confidential case records

You have a right to be part of the planning process and make informed choices about your plan. If you don't agree with your plan, you can appeal.

You have the right to be treated with dignity and respect, and must be served without regard to race, color, sex, age, creed, national origin or disability.

Disability Rights Michigan

Inform. Empower. Advocate.

Client Assistance Program (CAP)

800.288.5923
or 517.487.1755

www.DRMich.org

Disability Rights Michigan (DRM) is mandated by federal and state law to protect the legal rights of individuals with disabilities in Michigan. DRM receives part of its funding from the Administration on Intellectual and Developmental Disabilities, the Center for Mental Health Services-Substance Abuse and Mental Health Services Administration (SAMHSA), the Rehabilitation Services Administration and the Social Security Administration.

Total Copies: xxx Total Cost: $xxx Cost per unit: $.xxx Revised 8/2020

www.DRMich.org

The Client Assistance Program.

Are you a person with a disability who needs help in order to **work, attend school, or live independently?** Were you denied services? Are you unhappy with the services you have? Do you need to know your rights?

The Client Assistance Program (CAP) might be able to help you. CAP is a federally mandated information and advocacy program for people who need vocational rehabilitation or independent living services.

CAP can help you:

- Resolve problems you may have with your counselor.
- Improve communication with your counselor.
- Provide advocacy services including help with appeals and administrative proceedings.

Each state and territory has a CAP. In Michigan, CAP is operated by Disability Rights Michigan (DRM).

Vocational Rehabilitation.

Vocational Rehabilitation (VR) services help people with disabilities prepare for, get, and keep work.

VR services in Michigan are provided by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP).

Services may include:

- career counseling and guidance
- job development and placement
- adaptive technology evaluations
- devices and supports
- education on reasonable accommodations
- education and training for specific employment
- and more

MRS and BSBP also provide **pre-employment transition services (Pre-ETS)** to help students ages 14-26 prepare for work and postsecondary education.

Pre-ETS may include job exploration counseling, work readiness training, work-based learning experiences, post-secondary education counseling, self-advocacy and mentoring, and more.

VR services and Pre-ETS are based on each person's unique strengths and interests.

Independent Living.

Centers for Independent Living (CILs) were established by people with disabilities seeking full integration into society. Acknowledging that people with disabilities are the best sources of information about their personal goals and needs, CILs provide five core services:

- Independent Living Skills Training
- Peer Support
- Advocacy Work
- Transition
- Information and Referral

CILs help people with a wide range of disabilities become empowered to live independently in the community. CILs are sometimes known as "Disability Networks."

Our Services Are

Free & Confidential.

800.288.5923
or 517.487.1755

www.DRMich.org

Documents Required For Ramp Request

- ☐ **Application:** including completed
  - ☐ Application Form
  - ☐ Independent Living Plan
  - ☐ Request for Financial Assistance
  - ☐ Release of Information
- ☐ **Doctor's Prescription:** A doctor's prescription or medical statement of disability (must state—ramp required with specific diagnosis on prescription).
- ☐ **Home Ownership/Landlord Approval:** Written approval from landowner (if rental property) or proof of home ownership (e.g., copy of paid tax bill, deed or mortgage, etc.).
- ☐ **Proof of Income:** Proof of total household income per month.
- ☐ **Agreement to Participate** with disAbility Connections
- ☐ **Ramp Project Disclaimer** Form
- ☐ **Publication Consent and Release** Form
- ☐ **Ramp Information** Sheet
- ☐ **Ramp Assistance** Criteria
- ☐ **Customer Rights/Responsibilities** Form

Please note: *Applications are not considered accepted and complete until ALL of the required documents are received.*

Revised: 1/2/2024

Office Received: _____

dis*Ability* Connections Application for Service

Thank you for choosing dis***Ability*** Connections to assist you in reaching your goals. To help us serve you better, please complete this form. The information is confidential. Your signature on this form indicates you have a disability and believe you would benefit from our involvement.

Date	Staff	Would you like to receive Newsletter
		☐ Yes ☐ No

Name			Birthdate	Gender

Phone/Cell	Alternative Phone/Cell	Email

Street Address	City	State	ZIP

Significant Disability (check all that apply)

☐ ADD/HD	☐ Brain Injury/TBI	☐ Emotional Impairment	☐ Parkinson's Disease
☐ Agent Orange	☐ Cancer	☐ Epilepsy/Seizures	☐ Post-Traumatic Stress Disorder
☐ Alzheimer's	☐ Cardiovascular Disorder	☐ Fibromyalgia	☐ Post-Polio Syndrome
☐ Amputation	☐ Carpal Tunnel	☐ HIV/AIDS	☐ Pulmonary Disease
☐ Arthritis	☐ Cerebral Palsy	☐ Kidney Disease	☐ Short Stature/Little Person
☐ Asthma/Emphysema	☐ Chemical Sensitivity	☐ Learning Disability	☐ Spinal Cord Injury/Disorder
☐ Autism/Aspergers	☐ Cognitive Impairment	☐ Mental Health	☐ Stroke
☐ Autoimmune Disorder	☐ Deaf/Hearing Imp.	☐ Morbid Obesity	☐ Substance Abuse
☐ Back Injury	☐ Dementia	☐ Multiple Sclerosis	☐ Other (specify)
☐ Blind/Visual Impairment	☐ Depression	☐ Muscular Dystrophy	_____
☐ Bone/Joint Disorder	☐ Develop. Disability	☐ Narcolepsy	
☐ Brain Disorder	☐ Diabetes	☐ Not Disabled	

Race (check all that apply)

☐ American Indian or Alaskan Native	☐ Black / African American	☐ Native Hawaiian or other Pacific Islander	☐ Other / Unknown
☐ Asian	☐ Hispanic / Latino		☐ White / Caucasian

Armed Forces Status

☐ Active Duty	☐ Reserves	☐ Veteran	☐ None

Household Information

Describe your current living situation:			
☐ Own Home	☐ Rent-Subsidized	☐ Rent-non Subsidized	☐ Homeless

Number of adults in your household	Number of children under 18 in your household	

Annual Household Income (of all adults over 18)	Income Source(s):

List all Medical Insurance(s)

Guardianship Information

Do you have a guardian?	Guardian Name	Guardian's Phone Number
☐ Yes ☐ No		

Signature	Date

Parent/Guardian Signature (if applicable)	Date

Revised: 1/2/2024

Office Received: _____

Independent Living Plans – Tell Us Your Goals For This Service

All consumers of disAbility Connections are welcome to identify their specific Independent Living goals by completing the information below.

☐ Or, if you prefer, you may waive the development of an Independent Living Plan by checking this box and signing

Signature (Waive Development of Independent Living Plan)

Areas where you would like assistance:

☐ **Vocational:** I want to obtain or maintain employment, advance in my current job or launch my own small business (including market research, feasibility study, developing a business plan and/or securing start up funds).

☐ **Communication:** I want to improve my ability to understand what others are communicating to me and/or I want to improve my ability to communicate with others.

☐ **Mobility/Transportation:** I want to improve my ability to move freely within my home or access my community. (This may include the use of public transportation).

☐ **Community Services:** I want to change my living situation so that I have more control over my life. (This may include obtaining/modifying an apartment or house).

☐ **Educational:** I want to increase my knowledge through training or formal education to increase my independence.

☐ **Self-Care:** I want to improve or maintain my ability to complete activities of daily living such as personal grooming and eating, preparing meals, shopping, etc.

☐ **Information Access/Technology:** I want to obtain and/or use a computer, software, or other assistive technology, device or equipment.

☐ **Personal Resource Management:** I want to learn to establish and maintain a budget or manage a checkbook or obtain knowledge of available direct and indirect resources related to income, housing, food, medical, and/or other benefits.

☐ **Self-Advocacy/Self-Empowerment:** I want to improve my ability to represent myself with public and/or private entities (for example, Community Mental Health, schools, etc.) or improve my ability to make decisions.

☐ **Other:** I want to learn to accomplish goals that are not included in the above categories.

Please specify what you hope to accomplish in any of the goal areas you indicated above:
This is what I am responsible for when working toward my goals:
This is what I think disAbility Connections is responsible for while I am working toward my goals:

The following agencies/people are also assisting me as I work toward my goals:

Name	Telephone	How they are helping
1.		
2.		
3.		

Signature	Date
Parent/Guardian Signature (if applicable)	Date
dis***Ability*** Connections Representative Signature	Date

Office Received: _____

REQUEST FOR FINANCIAL ASSISTANCE

If you are requesting financial assistance from dis***Ability*** Connections, please provide the following additional information. (Note: disAbility Connections may require one or more of the following: a physician's prescription; a medical statement; and/or proof of financial need in order to consider your request).

What is your specific request?

What other agencies have you contacted for assistance and what was the response? *

Agency	Response
1.	
2.	
3.	
4.	

**If you received a decision letter from the Department of Human Services (formerly FIA), please attach a copy).*

As an applicant for financial assistance through disAbility Connections, your signature on this request indicates that you have read, understand and accept the following conditions and limitations:

1. Based on the applicant's ability to pay, there will be a co-pay of not less than 25% of the total amount of the request.
2. The disAbility Connections Services Committee/disAbility Connections Board is authorized to investigate and act on requests for financial assistance.
3. The recipient and/or beneficiary of a resulting grant shall indemnify and hold disAbility Connections, its Board of Directors and members harmless against and from any and all claims, demands, suits or other forms of liability that may arise out of, or by reason of, action taken or not taken.
4. I have read and understand the customer rights, responsibilities and appeal process information.

Participant Signature	Date
Parent/Guardian Signature (if applicable)	**Date**

For office use only

Date Reviewed	Request Approved	Co-Pay
Comments		
dis***Ability*** Connections Representative Signature		Date

Office Received: _____

RELEASE OF INFORMATION
TO
disAbility Connections, Inc.
409 Linden Avenue • Jackson, MI 49203

Release of information is necessary for dis***Ability*** Connections to contact other agencies for information concerning your request, or to advocate on your behalf. Example: Physician, Dept. of Human Services, Pharmacy, etc.

Individual or agency maintaining the requested information

Name	Address
1.	
2.	
3.	

I hereby request the record(s) of:

Participant Name	Address

To be released to dis***Ability*** Connections, access and copies of all information, including records related to substance abuse services (42 CFR, Part II).

Reason for Disclosure
Type of Information to be disclosed

It is further understood that this information is confidential and shall be disclosed to others to the extent consistent with the authorized purpose(s) stated above for which the information is being obtained. I understand that I may revoke this request by notifying an employee of dis***Ability*** Connections.

Participant Signature	Date
Parent/Guardian Signature (if applicable)	**Date**
Witness Signature	**Date**

Expiration at:	☐ Case closure, or ☐ One year from today's date, or ☐ Specific date of closure: _____

Agreement to Participate with disAbility Connections

I _____ agree to participate in
Participant Name

_____ Ramp Program _____ with disAbility Connections.
Program Name

Participant Signature	Date
Parent/Guardian Signature (if applicable)	Date

I also acknowledge that I have received and understand the following information from disAbility Connections:

(Check all that apply)

☐ Customer Rights Policy

☐ Customer Responsibilities Policy

☐ Customer Appeal Policy

☐ Services Available from disAbility Connections

☐ CAP Brochure

Participant Signature	Date
Parent/Guardian Signature	Date

For office use only

Date Reviewed	CILS First Entry Date	Staff Member

Revised 1/2/2024

Ramp Information Sheet

Name			
Ramp Location Address	City	State	ZIP
Driving Directions			

Type of equipment used: (check all that apply)

- ☐ Walker
- ☐ Manual Wheelchair
- ☐ Power Wheelchair
- ☐ Power Scooter
- ☐ Bariatric Walker
- ☐ Bariatric Manual Wheelchair
- ☐ Bariatric Power Wheelchair
- ☐ Bariatric Power Scooter

Is your disability due to: ☐ Accident ☐ Illness ☐ Other _____

Do any of the following apply to you?

- ☐ Veteran
- ☐ In the WellWise Wavier Program
  If yes, case manager's name: _____
- ☐ Have a DHHS Case Manager
  If yes, case manager's name: _____

For office use only

Notes

Revised 1/2/2024

Ramp Project Disclaimer Form

We/I hereby disavow any liability claim, present and future, against members of agencies and volunteer organizations involved in the dis***Ability*** Connections Ramp Project arising from the aforementioned volunteer assistance in building the agreed upon ramp to our/my homestead.

We/I understand that our/my signature on this form releases all members of agencies and volunteers from liability for damages or accidents arising during and after the agreed upon construction of the ramp.

We/I understand that each person involved in this project is a volunteer of the Jackson Ramp Project and that this program is sponsored by dis***Ability*** Connections and other non-profit volunteer organizations.

We/I do further release and discharge the said Jackson Ramp Project, dis***Ability*** Connections, it's agents, servants and employees of and from any and all claims, demands, actions or rights of actions which we/I have or may have against dis***Ability*** Connections for its part in arranging volunteer assistance for the purpose of building a wheelchair ramp.

As further consideration of said ramp, we/I hereby agree to protect the said dis***Ability*** Connections against any claim for damages, compensation or otherwise on the part of any other party, growing out of or resulting from injury in connection with the above mentioned ramp, and to reimburse or make good any loss or damage or cost that the said dis***Ability*** Connections may have to pay if any litigation arises from said injuries; and we/I hereby waive any and all rights of exemption, both as to real and personal property, to which undersigned may be entitled under the laws of this or any other State as against such claims for reimbursement or indemnity by the said releases.

We/I have signed this document of our/my own free will. We/I, the property owner/agent grant permission for the ramp and building/landscape changes at:

Property Address	City	State	ZIP

Print Name—Consumer	Consumer Signature	Date
Print Name—Parent/Guardian	Parent/Guardian Signature (if applicable)	Date
Print Name—Property Owner	Property Owner Signature	Date

Publication Consent and Release Form

We/I agree to the following (Please check each line that applies):

- ☐ Publication by Ramp Project about the ramp being built at my home;
- ☐ Publication by Ramp Project of photographs or use of videotapes of my home before and after the ramp is built.
- ☐ Publication by Ramp Project of photographs or use of videotapes of myself at my home; and or
- ☐ Use of the information and/or photographs/videotapes authorized above by other organizations or publications, with permission of Ramp Project.

Signature	Date
Parent/Guardian Signature (if applicable)	Date
Property Owner Signature	Date
Renter Signature (if applicable)	Date

Please Note: completion of this form is voluntary and will not affect our decision to construct a ramp.