

Please submit photocopies of the following documents along with your application.

NO GRANTS CAN BE PROCESSED WITHOUT SUPPORTING DOCUMENTS

Document Checklist

- ALL APPLICANTS: Complete the enclosed “PA Accessible Housing Program (PAHP) Release Form”
- ALL APPLICANTS: Have your primary care doctor fill out the enclosed Physician’s Recommendation Form. The doctor must either fax or mail it directly to us.
- or n/a SECTION 8 RECIPIENTS IN LANCASTER COUNTY ONLY: Please submit a copy of your rental agreement only; no income documents are needed.
- ALL APPLICANTS: Copy of the deed or rental agreement to the property to be modified.
- or n/a If anyone filed taxes last year, provide copies of the most current federal income tax returns for all adult household members.
- or n/a If anyone in the home works, provide copies of current pay stubs or other income statements for all adult (over 18) household members.
- or n/a If anyone in the household receives Social Security, provide an official statement saying what the monthly payment will be for the current year. (This applies to those above and below the age of 18). Direct deposit records on banking statements CANNOT be accepted for this.
- or n/a Copy of all checking and savings account statements for all people living in the home
- or n/a Balance statements for any pension, 401(k), IRA or other investment funds for anyone living in the home, if any.
- or n/a Monthly payment documentation for any public assistance, child support, food stamps and/or other sources of income for everyone in the home, if any
- or n/a Copies of any other income statements which you receive (please list below):

Return to: Accessible Home Modifications
United Disabilities Services
1905 Olde Homestead Lane
Lancaster, PA 17605-0485

For information or assistance call: 1-800-995-9581

Eligible Activities

1. Creating adaptive modifications such as ramps, lifts, door widening, visual door bells, audio phones, visual signalers, widening hallways, lowering kitchen counters, enlarging bathrooms, or adding grab bars that will increase the ability of a person with a disability to perform activities of daily living.
2. The Program may not be used to make repairs to the home or to correct code violations.

Eligibility Criteria

1. The property to be modified must be the Program Beneficiaries' primary residence and be located within the UDS contractual service range.
2. The Program Beneficiary may be the owner of the property to be modified; a lessee of the property to be modified; **or a member of the owner's or lessee's family.**
3. The Program Beneficiaries' disability must be verified by a physician's statement.
4. The property modified must be habitable and in structurally sound condition compliant with local building codes and ordinances.
5. The household to which the Program Beneficiary belongs must be a low to moderate income household as determined by UDS according to standards of the grant funding agency which supplies funding to the project. Annual income includes earned and unearned income from all household members 18 years old or older, excluding full time students, and unearned income for those under the age of 18.

Terms of Assistance

1. Financing provided through the Program will be provided on behalf of an eligible Program Beneficiary as a forgivable loan: **if you live in the home for 2 years after the modifications are made, you will not have to pay back the loan.**
2. If the Program Beneficiary stops using the modified property as his or her primary residence during the first two (2) years, then the entire loan must be repaid. The loan amount will be due in full on demand, within sixty (60) days of being so notified.

If the Program Beneficiary remains in the home modified through the Program for at least two (2) years following completion of the property modifications, the loan will be forgiven with 50% of the loan amount forgiven on the first anniversary of the project completion date and the balance of the loan amount to be forgiven on the second anniversary date of the project completion.

The repayment requirements may be waived or modified, at the discretion of the Program, under the following circumstances:

- a. If the Program Beneficiary sells or moves from a home that has been modified through the Program due to death, serious illness, or unforeseen complications of their disability; or
 - b. If the Program Beneficiary's household is required to move from the property because of actions taken by the property owner and not the result of actions of the Program Beneficiary's household, such as a sale of the property or the owner's refusal to renew a lease. This exception does not apply if the Program Beneficiary's household is required to move because of their violation of the terms of their lease.
3. Home modifications exceeding the beneficiary's approved maximum loan amount shall be the responsibility of the Program Beneficiary.

Your Contractor

Accessible Home Modifications tries to offer applicants as much control over selecting their contractor as they feel comfortable having. United Disabilities Services offers its own construction service, Accessibility Construction. Consumers typically choose to use our in-house construction company because our staff members are experts in the unique design needs of people with disabilities. Because our construction division is part of our nonprofit company and we do a large volume of projects, we are able to provide high-quality workmanship for a lower cost and save taxpayer dollars. The revenue generated by our construction operation also goes directly back into our agency's programs to help other local people with disabilities.

Consumers are also given the choice of selecting up to three contractors for a competitive bid process. Please see "Applicant's right to select contractors" on page 5 or contact our staff at 1-800-995-9581 for more information on that process. We provide the following tips for selecting your contractor:

Most problems occur when homeowners fail to investigate contractors carefully before hiring them. We suggest that homeowners always ask at least two or three contractors for bids on proposed home improvement work. We also suggest that homeowners check contractor references. Homeowners should talk with the references and take a look at some work done by contractors to find out if the customers were actually satisfied with the contractor's work. If you cannot get a recommendation from someone you know, we can provide you with a list of contractors who have completed work for us and who have passed our internal certification process.

1. **Don't discriminate when asking contractors to bid.** Homeowners cannot discriminate on the basis of race, color, creed, religion, sex, national origin, age, handicap status, or otherwise, as provided by the applicable law, in the selection of contractors to submit bids.
2. **Contractors must have insurance.** UDS requires all contractors to carry at least \$1,000,000 in general liability insurance.
3. **Bid Estimates:** Contractors must submit a detailed bid estimate listing all the work to be done, along with a price binding for at least 30 days.
4. **DO NOT SIGN ANY CONTRACTS PRIOR TO APPROVAL OF YOUR LOAN AND CONTRACTOR BIDS BY UDS.**

5. Value of residence: \$ _____

6. Assets:

Checking Account: \$ _____

Savings Account: \$ _____

Certificate of Deposit: \$ _____

Stocks/Bonds: \$ _____

Money Market: \$ _____

Real Estate other than primary: \$ _____

IRA's: \$ _____

TOTAL ASSETS: \$ _____

7. Demographics Information

The following information is requested by the federal government for statistical reporting purposes. You are not required to furnish this information, but are encouraged to do so. The law provides that a lender may neither discriminate on the basis of this information, nor on whether you choose to furnish it.

Ethnic Category:

Race Category:

_____ Hispanic or Latino

_____ Not Hispanic or Latino

- _____ White
- _____ Asian
- _____ American Indian or Alaskan Native
- _____ Black or African American
- _____ Native Hawaiian or Pacific Islander
- _____ Asian and White
- _____ Black or African American and White
- _____ American Indian or Alaska Native and White
- _____ American Indian or Alaska Native and Black or African American
- _____ Other Multi Racial Categories (describe): _____

8. Certification of Occupancy: list the names and ages of all people living in home, including applicant.

<u>Name</u>	<u>Age</u>	<u>Name</u>	<u>Age</u>	<u>Name</u>	<u>Age</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

9. Modification Requested, what changes would you like to make to your home?

10. Additional Needs or Services. You may be eligible for other services, in addition to home modifications. Please fill out the section below, checking ‘Yes’ or ‘No.’ Your answers will not effect your eligibility to receive home modifications.

Does the applicant currently receive in-home personal care services? Yes No

If, so who is your current provider? _____

Does the applicant need assistance with any of the daily activities below?

Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grooming	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Toileting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Meal Preparation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transferring in/out of wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Entering/exiting home	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Does the applicant currently receive services through any of the agencies/programs below?

MH/MR or Early Intervention	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Office of Aging	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Office of Vocational Rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Office on Long-Term Living	<input type="checkbox"/> Yes	<input type="checkbox"/> No
United Disabilities Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is the applicant currently in need of respite or personal care services? Yes No

Has the applicant received a home repair loan though the Lancaster County Redevelopment Authority? Yes No

11. Authorization to release information necessary to verify or complete this application

I authorize you to obtain a completed Medical Assistance Form 51 (MA51) from my doctor,

_____, in order to determine my priority eligibility status.
(fill in your Doctor’s name)

I also authorize you to release or obtain any information necessary to the completion of the housing modification I am requesting, including documents supporting my application to other home repair programs for which I may be eligible, my bank accounts, earned and unearned income and to make any other inquiries pertaining to my/our qualification for a grant from UDS. A copy of this letter may be treated as an original.

I agree to have United Disabilities Services disperse these funds, if allocated, and I shall show no discrimination whatsoever to race, color or creed upon the chosen contractor. I certify that I have read this letter and have received a copy of it. By signature below, I, as the applicant and/or the owner, hereby state that at this time this property is not for sale.

PRIVACY ACT NOTICE: This information is to be used by the agency collecting it or its assignees in determining whether you qualify as a prospective borrower under its program. It will not be disclosed outside the agency except as required and permitted by law. You do not have to provide this information, but if you do not, your application for approval as a prospective borrower may be delayed or rejected. If you have any questions, please feel free to contact UDS. Thank you for your cooperation.

12. I want to receive informational mailings regarding UDS services or programs that may interest me.

- Yes No

13. Applicant’s right to select contractors

I have been advised by Accessible Home Modifications that it is my right to submit qualified contractors for the bidding process in regards to the work to be completed on my home, if I choose to do so. I may also choose to use staff from UDS Accessibility Construction, if I do not wish to solicit bids from contractors myself. I also understand that, should I select the bid price of a contractor whose price is higher than the lowest qualified bidder, I will have to pay the difference in the bid price.

I have submitted _____ qualified contractors who are listed below.

- 1. _____
- 2. _____
- 3. _____

I understand that contractors must pass background, reference and insurance checks in order to qualify to be awarded work through Accessible Home Modifications, per program guidelines.

OR

I would prefer to have UDS Accessibility Construction handle my construction needs.

13. Beneficiary’s Responsibility to approve all project designs

I understand that United Disabilities Services will be providing funding through a forgivable loan and/or a grant directly to me. I agree that it is my responsibility to approve all proposed project designs and to determine whether or not they meet my personal accessibility needs. I understand that United Disabilities Services and its representatives are not occupational therapists or architects, and that it is my responsibility to locate and pay for occupational therapy or architectural reviews of all proposed plans if I feel that is in my interest.

The above information is furnished in the strictest of confidence and is solely for the use of the United Disabilities Services for the purpose of qualification in the housing rehabilitation program. I am aware that Section 1001 of Title 18 of the United States Code makes it a criminal offense to make a willfully false statement of misrepresentation to a department or agency of the United States as to any matter within its jurisdiction

I verify that all information provided in this application is true to the best of my knowledge; I agree to all the above stated clauses and conditions.

Applicant Signature

Guardian or Co-Applicant (if any)

DATE

DATE

Statement on Program Funding

United Disabilities Services is an independent nonprofit organization dedicated to its mission of “advancing the independence of people with disabilities and people over the age of 60.” We are not a part of government agencies or programs, like the Office of Aging or the Office of Long-Term Living.

UDS’ Accessible Home Modifications Program relies upon funding from a combination of government grants and private donations, in order to provide services to the community. Accessible Home Modifications is not a government agency or an entitlement program, like Social Security. At many points throughout the calendar year, the volume of requests for our assistance exceeds our program’s financial resources.

As a result, it may be necessary for some applicants to be placed on waiting lists until we are able to obtain the financial resources to help them. Our staff is dedicated to doing everything we can to help our consumers receive the home modifications they need and will explore all options at our disposal to do so. However, we cannot make guarantees regarding the availability of funding or specific timeframes wherein requested projects can be completed.

I have read and understand the statement above. If I have any questions regarding the above statement, I can call 1-800-995-9581 and ask to speak with Accessible Home Modifications Staff.

Applicant Signature

Guardian or Co-Applicant (if any)

DATE

DATE

**Conditional Approval of Property Modifications by Property Owner
or Representative (if different from Applicant)**

Address of Property to Modify: _____

Applicant, _____, has my conditional permission to modify my property to make
(name of Applicant)

it accessible to applicant or a member of applicant's family/household. This permission is subject to my approval of all bid estimates, contractors and construction plans related to the property. I understand that no changes to my property will take place without a formal signed agreement between me and United Disabilities Services, which will include final modification plans and the contractual expectations of any contractors working on the modification, and which releases me from any financial obligation for the modification.

(Property Owner or Representative Signature)

(Date)

Landlord Contact Information:

(Print Name of Landlord)

Phone _____ Mobile _____

Fax _____ Email _____

Mailing Address

PA Accessible Housing Program (PAHP) Release Form

1. I agree to participate in the State of Pennsylvania’s efforts to obtain financial participation from the federal government to fund home modifications for individuals that can be safely served in the community.
2. I authorize the Department of Community and Economic Development (DCED) to release to the appropriate agency information regarding my receipt of PAHP funds.
3. I authorize being contacted by the Department of Public Welfare (DPW) in order to determine my eligibility for the Medical Assistance Program.
4. I will provide or cooperate in getting any information needed.
5. I understand that:
 - a. This project is being conducted in order to allow the state to provide assistance to more individuals who may find themselves facing the same accessibility issues that I once encountered.
 - b. This will not affect my receipt of assistance from the PAHP.
 - c. My Social Security Number will only be used to obtain information to verify my eligibility.
 - d. My information is confidential and will be used only to administer the programs for which I may apply or be eligible. The DPW and its health and human services program will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
 - e. This authorization may be revoked at any time by writing to the DCED or the DPW except to the extent that information has already been disclosed. If information has been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
 - f. The DPW its programs, services, employees, officers, and contractors and DCED are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
 - g. I may refuse to sign this authorization.

Individual’s Name (PLEASE PRINT)

Signature of Individual or Personal Representative

Individual’s Social Security Number

Date

Address

City, State, Zip Code

Physician's Recommendation for Accessible Home Modifications

Date: _____

Dear Physician: Your patient has applied to receive a Grant to pay for an Accessibility Modification to their home, so that they can continue living at home safely. In order for your patient to receive these services it is a requirement that you complete this form indicating their primary diagnosis including appropriate DX Code. We can not provide the grant without medical confirmation of a disability and medical necessity.

Patient Name: _____

Address: _____

Primary Diagnosis: _____ DX Code: _____

Diagnosis: _____ DX Code: _____

Diagnosis: _____ DX Code: _____

Would the patient benefit from any of the following accessibility modifications to their home:

- Entry ramps/lifts Interior Stairlifts Bathroom modifications Wheelchair accessibility
- Permanently installed medical equipment Other _____

By signing this form, I certify that the above named person has the indicated diagnosis and qualifies for the following level of care (**PLEASE NOTE:** marking *Nursing Facility Eligible* is **NOT** a recommendation that your patient enter a nursing home. Home Modifications are specifically intended to keep your patient **at home**, through modifications which will allow them to receive appropriate care in their own homes) **This information is used solely to determine the priority of your patient on our waiting list for services:**

_____ **Nursing Facility Eligible-** Medically eligible for Nursing Facility care with services to be provided at home.

_____ **Not Medically Eligible** for Nursing Facility Care at this time.

Please sign this form and include your physician's license number below:

X _____ Physician's Signature

X _____ Physician's License Number

X _____ Physician's Phone Number

Please fax completed form to the attention of Jessica Mullaney, Fax: (717) 293-1595.

If you have any questions please call Jessica Mullaney, Phone: (717) 397-1841. Thank You.