Area Agency on Aging - Region 9, Inc.
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Serving Ohio's Belmont, Carroll, Coshocton, Guernsey, Harrison, Holmes, Jefferson, Muskingum, and Tuscarawas counties for over 40 years

Purpose

The Area Agency on Aging, Region 9 (AAA9) Foundation was created in 2020 to assist older adults and disabled adults who fall through the "cracks" of traditional assistance programs, are victims of elder abuse or exploitation, of a natural disaster, or in need of other types of assistance to help them maintain their independence. Because the AAA9 Foundation depends on donations and has limited funds, we strive to be the payor of last resort, when practical and possible. Assistance is only available when funding is available.

Eligibility

To be eligible for assistance, the individual must reside in the AAA9 region. Individuals must be age 60 or over, or at least 18 with a documented physical disability. AAA9 Foundation assistance is not based on financial eligibility; however, referral candidates must have no other means of addressing their needs.

The need must concern a matter of health and safety; continuance of independent living; food and/or shelter needs; natural disaster recovery; or address a need specific to exploitation and/or elder abuse. Other types of requests will be considered on a case-by-case basis.

If the applicant being referred for assistance meets the eligibility criteria, please complete the form below.

Section 1: Information of Individual Needing Assistance

Please enter the following information as it relates to the individual.

Name (First and Last):

Date of Birth:

Phone number:

Address:

Name of person making referral:

Phone number of person making referral:

Relationship to referred (Place of employment and title if applicable):

Section 2: Assistance Needed

Assistance requested:

Approximate cost estimate:

Breakdown of cost (attach quote if possible)

Name or Utility Company involved:

Person or Company phone number:

Contact person if applicable:

Section 3: Alternative Resources

The AAA9 Foundation must be a payor of last resort.

Have you reached out to other organizations to meet these needs?

☐Yes

☐No

Please list other organizations contacted and explain the barrier to receiving assistance from them.

Organization Name/Address	Reason for denial

Does the person referred have family living within fifty miles?

☐Yes

☐No

Is the person being referred willing to accept alternative community services, if available?

☐Yes

☐No Reason:

Is the person being referred enrolled in a program coordinated by the Area Agency on Aging, Region 9?

☐Yes   If yes, which program?

Who is the consumer's case manager?

If answered yes, skip to Section 5.

☐No   If no, complete Section 4.

Summary of situation* *Use size 10 font or smaller*

Section 4: Applicant Agreement to Assessment

All applicants that are not enrolled in a program coordinated by the Area Agency on Aging, Region 9, must be willing to speak with an Intake Specialist to complete a Long-Term Care Questionnaire. By completing a questionnaire, and when appropriate, the applicant may benefit from referrals to additional programs or resources.

Is the applicant willing to complete a Long-term Care Questionnaire?

☐Yes

Who should be contacted for scheduling the Questionnaire?

Preferred Method of Contact

Telephone Number or Email Address Preferred

☐No

All applicants that are not enrolled in a program coordinated by the Area Agency on Aging, Region 9, must be willing to meet with a Long-Term Care Specialist to complete a Long-Term Care Consultation. By meeting with an AAA9 Long-Term Care Specialist, applicants may

benefit from enrollment in appropriate waiver programs and/or linked to community resource

Is the applicant willing to complete a Long-Term Care Consultation?

☐Yes

☐No

Section 5: Signature and Date

I understand that the Area Agency on Aging, Region 9 Foundation must be the payor of last resort for financial assistance. If not found eligible for financial assistance through the Foundation, AAA9 staff will assist in linking the applicant to appropriate community resources.

___________________________________ ______________________

Signature Date

Thank you for your referral to the AAA9 Foundation. Staff will make 3 attempts to contact you if additional information is needed. It is important to answer telephone calls and/or monitor email to remain in the application process.

FOR OFFICE USE ONLY

AAA9 staff completing Referral Request Form, list two or more alternative resources given to applicant.

1.
2.

Supervisor's Signature: ____

Date Supervisor Reviewed: __/__/__

Date Discussed in Clinical Review __/__/__

☐Application accepted

☐Application denied

Reason denied:

Additional notes: