Southeastern Ohio Center for Independent Living (SOCIL)

Consumer Assistance Program Application

- Fairfield County Office: 418 South Broad Street Lancaster, Ohio 43130 – 740-689-1494
- Hocking County Office: 96 West Hunter Street Logan, Ohio 43138 – 740-689-1494

Assisting Individuals with Disabilities and Their Families

SOCIL believes that people with disabilities have the right to choices and opportunities in society that support and maximize their empowerment, inclusion, leadership, independence, and full participation in community life. Centers for Independent Living are unique in that we serve the consumers of our community specifically related to their needs. To that end, through our consumer assistance program SOCIL is considering requests to secure technology devices or software, PPE, or transportation assistance. SOCIL will approve the applications based on need and available resources. Applicants will be required to submit all requested documentation. Incomplete applications will not be considered, no exceptions.

"Per the Americans with Disabilities Act, qualified individuals must have a disability or be the care-giver of a person with a disability which impacts a major life area. The condition must be permanent. If the condition is in remission it must impact a major life area when active. Those with a history of drug use must be in recovery to qualify and that history of drug use must currently impact a major life area."

Who can apply:

- Individuals with disabilities or Guardians of PWD (People with Disabilities)

All applicants are required to provide the following documents:

- Proof of Identity
- Proof of Current Address
- Proof of Disability
- Quote for the cost of the Device or Software
- Explanation as to how this assistance will allow you or the recipient to remain or become independent

Documents accepted as proof of disability are as follows:

- Statements or letters from a physician, medical or mental health professional (on their letterhead)
- Statements, records, or letters from a Federal Government agency that issues or provides disability benefits
- Statements, records, or letters from a State Vocational Rehabilitation Agency counselor

If the applicant is not able to submit all of the required documentation within reason, they should contact the SOCIL Executive Director for further assistance. All applications will be reviewed in the order in which they are received.

To request a paper application, contact SOCIL by phone or you can visit socil.org to download an electronic application.

Consumer Assistance Program Application for People with Disabilities

Applicant Information:

Full Name: Last, First, M.I. Date of Birth:

_____ _____

Address: Street Address Apartment/Unit #

_____

City State ZIP Code

_____

County of residence: _____

Phone: _____ Email: _____

I am a person with a disability: YES ___ NO ___

What is your disability? _____

I am the legal guardian of a person with a disability: YES ___ NO ___

If yes, what is their disability? _____

Individuals name: _____

Date of Birth: _____

Does disability affect one or more of your activities of daily living? YES ___ NO ___

If yes, explain: _____

_____

Service or Services being requested?

PPE (Personal Protective Equipment): YES ___ NO ___

Explain: _____

Transportation Assistance: YES ___ NO ___

Explain: _____

Adaptive Technology Assistance: YES ___ NO ___

Explain: _____

Disclaimer and Signature:

I certify that the above information is true and complete to the best of my knowledge. If this application is accepted by Southeastern Ohio Center for Independent Living and found that false or misleading information has been provided my application will be denied.

I certify that Southeastern Ohio Center for Independent Living will provide me with services needed due to my disability. I understand that if I receive cash assistance that it may not be used for the purchase of alcohol or tobacco products.

Signature: _____ Date: _____

Office Use Only

Date Received: _____ Staff: _____

Required Documentation Received: YES ___ NO ___

Approved: YES ___ NO ___ Executive Director Approval: _____

Description of assistance approved: _____

_____

Follow up Date (within 30 days): _____

Notes: