CCTA—Center for Creative Therapeutic Arts **FHN Client#:__________________**
FY10 Fund for a Healthy Nevada (FHN)
Grant for Independent Living & Homelessness: Life Skills Training

ELIGIBILITY FORM FOR INDIVIDUALS

Complete this state required form to pre-qualify for music therapy services provided at no charge.
(To qualify, clients must be at least 4 years old and children 12 and under must have at least 3 ADL's)
Date Completed:___________________ Referral Agency____

Client First Name_____________________________ Last Name___________________________________

Ethnicity (circle): AA Hisp Asian C other_______________ Date of Birth:_____________(ages 4 and up)
Diagnosis/Illness:____

Current/Past Therapies received:____

If the person completing this form is not the client, please print:
First/Last Name ____ Tel #____________________
Relationship to client:_________________________Agency:__________________________ ___________

Check one of these two area(s) to pre-qualify for music therapy services:
___ Receives Social Security Disability Insurance (SSDI) (attach approved SSDI form)
OR
___ Possesses limitations due to an illness or medical condition to independently perform any combination of three (3) or more of the following **ADL's** or **IADL's** (check all that apply).
(Children age 12 and under must possess limitations of at least three ADL's. IADL's do not usually apply to children.)

Activities of Daily Living (ADL) relate to personal care.
__ bed mobility
__ transfer (move from one place to another-mobility)
__ locomotion
__ dressing
__ eating/feeding
__ hygiene
__ bathing
__ bladder care
__ bowel care

Instrumental Activities of Daily Living (IADL) relate to independent living – (age 13 and up)
__ preparing meals
__ managing money
__ shopping for groceries or personal items
__ performing light or heavy housework
__ using a telephone

Please indicate the following range of client's annual income and family size to receive free music therapy services or check the line if income and family size differ from these levels.
__ below $11,000 with family size of 1+
__ $11,001-15,000 with family size of 2+
__ $15,001-18,000 with family size of 3+
__ $18,001-22,000 with family size of 4+
__ $22,001-26,000 with family size of 5+
__ $26,001-30,000 with family size of 6+
__ *Income and family size differ from these levels. I will bring income verification to complete the co-pay agreement during my intake.*

(Please fill in all contact information and designate whether client, caregiver, or agency information.)
Name: ____________________________________ Client ___ Primary Caregiver ___ Agency ____
Mailing Address:____
City______________________ Zip____________ Email _______________________________
Tel (H)______________________ (C)________________________ (W)_________________________
I, __________________________________ (print name), certify that the above information is true.
____ **(signature)**

Please fax this completed form to CCTA at (702) 315-4362. Tel (702) 363-8166 lasvegas@ccta.us www.ccta.us