Application for Services

"Offering a new beginning to those that need it most"

Please attach a copy of the following

☐ Guardianship/Conservatorship
☐Power of Attorney
☐Social History
☐Funeral Trust
☐Current Case Manager plan

Today's Date: **Name of Person completing Application**

Relationship to Applicant:

APPLICANT				
Full Name:	**Sex : M☐ F ☐**	**Date of Birth:**	**Age:**	
Current full Address:			**Phone:**	
Social Security Number:				
Services applying for: Supported Community Living Hourly ☐				
Supported Community Living Daily ☐				
Funding For Services: ID Waiver ☐	**100% county funded ☐**		**Private Pay ☐**	
Managed Care Organization:				
Primary Disability (Degree and Type)				
Other Diagnosis:				

CONTACT INFORMATION				
Case Manager/Care Coordinator:			**Phone:**	
Email:	**Full Address:**			
Family Contact:	**Relationship with Applicant:**			
Phone:	**Email:**		**Full Address:**	

SERVICES NEEDED				
Ambulatory: Yes ☐ No ☐	**Primary Language and method of communication:**			
Unsupervised needs:				
• **In home:**				
• **In the community:**				
Expectation of Services:				

OTHER AGENCIES INVOLOVED				
Agency Name:	**Contact Name:**	**Phone number:**	**Address:**	**Services Provided:**
Agency Name:	**Contact Name:**	**Phone number:**	**Address:**	**Services Provided:**
Agency Name:	**Contact Name:**	**Phone number:**	**Address:**	**Services Provided:**
Agency Name:	**Contact Name:**	**Phone number:**	**Address:**	**Services Provided:**

Please attach a copy of the following

☐ Guardianship/Conservatorship
☐ Power of Attorney
☐ Social History
☐ Funeral Trust
☐ Current Case Manager plan

1

FINANCIAL/LEGAL INFORMATION

Do you have a legal Guardian: Yes☐ No☐	**Date of Guardianship:**
Guardian Name:	**Relationship if any:**
Guardian Name:	**Relationship if any:**
Do you currently have Medicaid insurance Yes☐ No☐	**Insurance number:**
Do you currently have Medicare insurance Yes☐ No☐	**Insurance number:**
Do you currently have Private insurance Yes☐ No☐ Company:	**Insurance number**
Do you have a Payee: Yes ☐ No ☐ Payee Name:	
Do you receive Financial assistance: Yes ☐ No ☐	**Type of assistance:**
monthly amount:	**will this number change: Yes ☐ No ☐**

MEDICAL

Do you have any physical disabilities that require the use of special devices? (Wheelchair, braces, walker, orthopedic shoes, splints, canes, etc.) **Yes ☐ No ☐ Please explain:**

Current Medications:

Medication	Dose	Frequency	Reason for Medication

Please attach a copy of the following

Guardianship/Conservatorship
Power of Attorney
Social History
Funeral Trust
Current Case Manager plan

Physicians/Specialist

Primary Doctor:		**Address:**	**Phone:**	**Date of last Exam:**
Dentist:		**Address:**	**Phone:**	**Date of last Exam:**
Psychiatrist:		**Address:**	**Phone:**	**Date of last Exam:**
Therapist:		**Address:**	**Phone:**	**Date of last Exam:**
Optometrist:		**Address:**	**Phone:**	**Date of last Exam:**
Podiatrist:		**Address:**	**Phone:**	**Date of last Exam:**
Neurologist:		**Address:**	**Phone:**	**Date of last Exam:**
Other:		**Address:**	**Phone:**	**Date of last Exam:**

Have you been hospitalized in the last 5 years: Yes☐ No☐	**Explanation:**
Have you received mental health services in the last 5 years: Yes☐ No☐	**Explanation:**

Seizures

Do you have seizures: Yes☐	**No ☐**	**Date of last Seizure**
Frequency of Seizures		
Describe what a typical seizure looks like:		

Allergies

Are you allergic to any of the following			
Food:	**Yes ☐**	**No☐**	**Name of food(s) and allergic reaction(s)**
Medication:	**Yes ☐**	**No☐**	**Allergic reaction(s)**
Other:	**Yes☐**	**No☐**	**Allergic reaction(s)**

Diet

Are you on a special Diet: Yes ☐	**No☐**	**Please explain:**

EDUCATIONAL/DAY HABILITATION/VOCATIONAL HISTORY		
Current or Last School:	**Phone:**	**Address**
High School Graduate? Yes☐ No☐		
Employer/Agency:	**Phone:**	**Address:**
Employer/Agency:	**Phone:**	**Address:**

Please attach a copy of the following

Guardianship/Conservatorship
Power of Attorney
Social History
Funeral Trust
Current Case Manager plan