



EMPOWERING PEOPLE WITH INTELLECTUAL DISABILITIES TO ACHIEVE THEIR HIGHEST QUALITY OF LIFE

APPLICATION FOR SERVICES

IDENTIFYING INFORMATION:

Name of Person Seeking Services:

(Last) (First) (Middle) (Nickname)
Social Security Number: _____ Birth Date: _____
Current Address: _____ Phone Number: _____
(Street)

(City) (State) (Zip Code) County of Legal Residence: _____
Sex: _____ Marital Status: _____ Height: _____ Weight: _____
Ethnicity: _____ Caucasian _____ African-American _____ Asian _____ Hispanic
_____ Native Indian _____ Other _____ Unknown
Religion: _____ (optional)
Name of person supplying information (if different from applicant): _____
Relationship to applicant: _____ Date form completed: _____
Date admission is desired: _____

SERVICES SOUGHT:

Below is a list of services provided by Area Residential Care. Please check all the applicant may be interested in.

Residential

_____ Community Living Home (4 to 6 residents) _____ Awake night staff, or: _____ Sleeping night staff
_____ Community Living Home (ICF/ID) (*always awake night staff*)
_____ Supported Community Living (staff stop in at current living place for training as arranged)
_____ Parental Home _____ Own Apartment/House

Vocational/Day Programs

_____ Community Based Enclave Work Site (work group; staff always present during work hours)
_____ Community Based Individual Employment/Job Coaching (staff periodically visit to check on)
_____ Job Development (help finding a community job)
_____ Day Habilitation (day program to assist with life skills/community integration)
_____ Vocational Assessment (short term assessment of work skills and interests at various job settings)
_____ Other (please describe): _____

GUARDIAN/CONSERVATORSHIP INFORMATION:

Does the applicant have a legal guardian? _____ Name: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date Appointed: _____ County: _____

Does the applicant have a legal conservatorship? _____ Conservator: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date Appointed: _____ County: _____

Does the applicant have a representative payee? _____ Payee: _____

FAMILY INFORMATION:

Mother's maiden name _____

Emergency Contact Person Name: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ Work Phone Number: _____

Family Members Who Are Significant in Applicant's life:

Name: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ Work Phone Number: _____

Name: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ Work Phone Number: _____

Name: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ Work Phone Number: _____

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 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ Work Phone Number: _____

HEALTH & DISABILITY RELATED INFORMATION:

Applicant's primary diagnosis: _____

Applicant's secondary diagnosis (if any): _____

Date of applicant's most recent psychological exam: _____

Primary Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Dentist: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Hospital Preference: _____ Address: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Does the applicant currently have or has he/she ever had any of the following (if so, please describe):

Seizures or convulsions ___ Yes ___ No Describe: _____

Physical limitations or mobility impairments ___ Yes ___ No Describe: _____

Sensory impairments ___ Yes ___ No Describe: _____

Speech or language impairments ___ Yes ___ No Describe: _____

Emotional or mental health problems ___ Yes ___ No Describe: _____

Behavioral difficulties ___ Yes ___ No Describe: _____

Serious injuries: ___ Yes ___ No Describe: _____

Special equipment required: ___ Yes ___ No Describe: _____

Please list and describe any hospitalizations or surgeries: _____

Describe any on-going health problems: _____

List any allergies: _____

HEALTH & DISABILITY RELATED INFORMATION (CONTINUED):**Previous Illnesses** (List Date: mo/yr)

Chicken Pox _____

Ear Infections _____

Measles _____

Tonsillitis _____

Mumps _____

Asthma _____

Polio _____

Hay fever _____

Diabetes _____

Hepatitis _____

Tuberculosis _____

Cardiac _____

Previous Surgeries: _____

Immunizations (Attach physician documentation/immunization records):**Date Received****Date Received****Date Received**

Measles: _____

Flu: _____

Polio: _____

Mumps: _____

DPT: _____

Typhoid: _____

Rubella: _____

Mantoux/TB test: _____

Tetanus: _____

Please list any current medications, dosage, and prescribing physician:**Medication****Dosage****Prescribing Physician**

EDUCATIONAL / RESIDENTIAL / VOCATIONAL HISTORY:

Type of School	Name of School	Location	Program or Level	Year Completed
High School				
Post High School				

Please list below any previous jobs held, or jobs tried as part of vocational exploration / training:

Job Title	Dates Worked	Pay Rate	Brief Description of Job Tasks	Reason for leaving
1.	/	\$		
2.	/	\$		
3.	/	\$		

Please list below any previous residential or in-home services that have been received:

Name of Agency	Location	Service(s) Received	Dates of Service(s)	Reason service(s) ended?
			__/__/__ - __/__/__	
			__/__/__ - __/__/__	

Does the applicant have any of the following sources of financial support?

SSI _____ if so, amount: _____
 Social Security Disability _____ if so, amount: _____
 Veterans Benefits _____ if so, amount: _____
 Railroad or Other _____ if so, amount: _____
 Other Sources of Income _____ if so, amount: _____

Please complete any of the following that apply:

Name of Medical Insurance Provider: _____

Medicaid Number: _____

Medicare Number: _____

Name of MCO Provider: _____ MCO Identification Number: _____

Funding Representative/Case Manager: _____

Case manager phone number: _____ email: _____

Funding type (e.g. ID Waiver, ICF/ID, etc): _____

SKILLS CHECKLIST:

Check items that best describe applicant.

*If consistently is marked for the first line (completely independent) remaining lines do not need to be completed for that section.

FEEDING	Consistently	Sometimes	Never	Comments
Completely independent *				
Requires physical assistance				
Throws or plays with food				
Eats with fingers				
Uses cup or glass				
Eats with spoon				
Eats with fork				
Uses knife for spreading				
Uses knife for cutting				
Eats slowly				
Eats rapidly				
Shows good table manners				

SKILLS CHECKLIST (CONTINUED):

Check items that best describe applicant.

*If consistently is marked for the first line (completely independent) remaining lines do not need to be completed for that section.

DRESSING	Consistently	Sometimes	Never	Comments
Completely independent *				
Requires physical assistance				
Resists dressing				
Assists in dressing				
Puts on most clothing indep.				
Buttons clothes				
Ties Shoes				
Chooses own clothing				

GROOMING	Consistently	Sometimes	Never	Comments
Completely independent *				
Totally dependent				
Washes hands				
Washes face				
Brushes teeth				
Combs or brushes hair				
Bathes self independently				
Shaves self				
Shampoos hair				

TOILETING	Consistently	Sometimes	Never	Comments
Cares for self during menstruation *				
Completely independent *				
Requires control briefs				
Scheduled toileting				
Can indicate need				
Wets/soils during the day				
Wets/soils during the night				
Cares for self at toilet				

SOCIAL RELATIONS	Consistently	Sometimes	Never	Comments
Needs close supervision				
Avoids interaction with peers				
Enjoys interaction with peers				
Involves self near, but not with peers				
Disrupts group activities				

SKILLS CHECKLIST (CONTINUED):

Check items that best describe applicant.

*If consistently is marked for the first line (completely independent) remaining lines do not need to be completed for that section.

COMMUNICATION	Consistently	Sometimes	Never	Comments
Does not respond to language				
Communicates with gestures only				
Speaks single words				
Uses phrases				
Uses sentences				
Speech easily understood				
Follows simple directions				
Answers questions				
Converses spontaneously				
Talks on telephone				
Prints/Writes				

HUMAN SEXUALITY	Consistently	Sometimes	Never	Comments
Demonstrates knowledge of own sexuality				
Demonstrates knowledge of others' sexuality				
Masturbates privately				
Masturbates publicly				
Actively displays interest in same sex				
Actively displays interest in opposite sex				

CHORES AND ACTIVITIES	Consistently	Sometimes	Never	Comments
Helps with minor household tasks				
Does responsible routine chores				
Goes about neighborhood without supervision				
Makes purchases				
Uses public transportation buses/taxi				

BEHAVIORS	Check if Yes	Comments/Explain
Hyperactive		
Aggressive		
Withdrawn		
Hits/kicks others		
Bites others		
Pulls others' hair		
Self-stimulates, i.e. rocks back and forth		
Uses disruptive noises		

SKILLS CHECKLIST (CONTINUED):

Check items that best describe applicant.

*If consistently is marked for the first line (completely independent) remaining lines do not need to be completed for that section.

BEHAVIORS	Check if Yes	Comments/Explain
Engages in self-injurious behavior		
Abusive of property		
Leaves premises without permission		
Physically abuses others		
Screams		
Eats inappropriate objects/fluids		
Engages in rectal digging		
Other significant behaviors		

If other, explain: _____

CRIMINAL HISTORY:

Does the applicant have a criminal history? _____

If yes, please explain any criminal charges and/or related court conditions (i.e.: probation status, no contact orders, etc):

Application completed by: _____

Current Address: _____

City: _____ **State:** _____

Email: _____

Date: _____

Phone Number: _____

Zip Code: _____