Application for Day Support Services

Personal Information

Applicant Full Name: _____
Current Address: _____
City, State, Zip Code: _____
Sex: _____ Race: _____
Social Security Number: _____ Date of Birth: _____
Medicaid Number: _____ Medicare Number: _____
Other Insurance: _____
Group Number: _____ Policy Number: _____

Has the court named someone as the legal guardian? □Yes □No
A Legally Appointed Representative (LAR)? □Yes □No
If so, give the guardian's/LAR's name address and phone number:

_____

_____

_____

Criminal Justice Status: _____

Emergency Contact Person

Name: _____
Address: _____
City, State, Zip Code: _____
Phone (day): _____ Phone (Night): _____
Relationship: _____

SOCIAL & DEVELOPMENTAL SUMMARY

Describe the Applicant's Previous Service History (In what programs have they been enrolled? When, and for how long?):

Describe the Applicant's current behavior functioning including strengths & needs (What can they do? What do they need to learn?):

Documentation of need for services (Please describe what the Applicant and Family hope to gain by participating in the service.):

FAMILY SUMMARY

Father:_____ Occupation: _____
Address:_____
Phone (day): _____ Phone (night): _____

Mother:_____ Occupation: _____
Address:_____
Phone (day): _____ Phone (night): _____

Brothers & Sisters (name, age, sex): _____
_____

Other relatives interested or involved in Applicant's life: _____
_____

Describe the applicant's current family structure and relationships. Also, describe the anticipated future involvement of the applicant's family (i.e. visits, phone calls, updates by staff):

Describe the applicant's typical social activities, food and entertainment preferences and interactions with others:

MEDICAL HISTORY

Indicate if the applicant has or has ever had any of the following illnesses and/or chronic conditions:

Yes	No	Epilepsy, CP, MS, Parkinson's, Neuritis, Paralysis, Alzheimer's disease or any disease of the Central Nervous System. (please circle)
Yes	No	Heart Attack, murmur or palpitations or high blood pressure, anemia, varicose veins, or any disease of the heart, blood or blood vessels. (please circle)
Yes	No	Tuberculosis, asthma, pleurisy, or any disease of the lungs, bronchial tubes, throat, or respiratory system. (please circle)
Yes	No	Ulcer, indigestion, colitis, gall stone, hernias or any disease of the stomach, intestines, rectum, gall bladder or liver. (please circle)
Yes	No	Urinary sugar, albumin or stone, sexually transmitted disease, menstrual disorder or any disease of the breast, kidneys, prostate, urinary or genital systems. (please circle)
Yes	No	Diabetes, gout, or any disease of the thyroid or other glands. (please circle)
Yes	No	Arthritis, rheumatic fever, back trouble or any disease of the joints, muscles or bones. (please circle)
Yes	No	Clinical depression, Schizophrenia, Bipolar Disorder or any mental health illnesses. (please circle)
Yes	No	Mental Retardation, Autism, Developmentally disabled or any other developmental disabilities. (please circle)

Current significant medical problems, communicable diseases or recent physical complaints:

Past significant medical problems (serious injuries or illnesses or hospitalizations):

Serious illnesses or chronic condition of parents, siblings and other relatives:

Applicant's substance abuse history including, onset of use, types of substances, frequency of use, quantity of use, method of administration

Physician information

Name, Address and phone number of current physician:

MEDICATION PROFILE

List current prescription and non-prescription medications:

Medication	Dosage/Times given	Reason

List any food, drug or other allergies:

Are there any medications or treatments the applicant should not have?

Seizure History

History of Seizures □Yes □No □Unknown

Are seizures under control? □Yes □No □Partially □Unknown

Seizures are controlled by □medication □alternative methods

SERVICE NEEDS

Applicant can function without supervision for:

□Never □Up to 15 minutes □Up to 1 hour □All day Other:_____

Motor Skills:

How frequently does applicant require support or assistance with walking or standing?

□Rarely □Sometimes □Often □Always

Does the Applicant use a: □Walker □Wheelchair □Other Equipment

Social and communication Skills:

How frequently does the applicant require support or assistance in making his or her needs know or getting along with others?

□Rarely □Sometimes □Often □Always

What is the applicant' primary means of communication?

□Verbal Speech □Sign Language □Gesture, Communication Board
□Vocalization (no speech)

Personal Living Skills:

How frequently does the applicant require support or assistance with eating, dressing, using the bathroom or personal hygiene?

□Rarely □Sometimes □Often □Always

Community Living Skills:

How frequently does the applicant require support or assistance with being safe around traffic, recognizing an emergency, telling time, shopping or working?

□Rarely □Sometimes □Often □Always

Documented Disabilities

□Mild Intellectual Disability □Moderate Intellectual Disability □Severe Intellectual Disability
□Profound Intellectual Disability □Autism □Learning Disabled □Other_____
□Schizophrenia □Bi-polar □Depression □Personality disorder □Other_____
□Hearing Impaired □Cerebral Palsy □Visually Impaired □Other_____

Behavioral Supports:

Describe any behavioral supports that have proven to be successful for the applicant:

_____

_____

_____

_____

HISTORY OF RESIDENTIAL TREATMENT, INSTITUTIONALIZATION OR WAIVER SERVICES

Please provide a 5 year history

Name of Agency or Institution	Address	Dates	Service Provided

Other Social Service Agencies /Professionals Involved with Applicant:

Agency/Professional	Contact Person/Phone	Dates	Service Provided

Additional Comments:

Form Completed by: _____

Relationship to Applicant: _____

Date: _____