Application for Medicaid Waiver Services

Please check the services for which you are applying.

☐ Group Day ☐ Supported Employment

Do you currently have a Medicaid Waiver?

☐ Community Living ☐ Family and Individual Services
☐ Building Independence ☐ No Medicaid Waiver

Personal Information

Applicant's Name: ______________________
Address: ______________________
Cell phone #: ______________________
Home phone #: ______________________
Other phone #: ______________________
Email address: ______________________
Date of birth: ______________________
Gender: ______________________
Race: ______________________
Marital status: ______________________
Primary language: ______________________
Social Security #: ______________________
Medicaid #: ______________________
Medicare #: ______________________
Other Insurance: ______________________
Group #: ______________________
Policy #: ______________________

Legal guardian? ☐ Yes ☐ No

Legal Guardian's Information

Name: ______________________
Address: ______________________
Cell phone #: ______________________
Home phone #: ______________________
Other phone #: ______________________
Email address: ______________________

Emergency Contact Information

Name: ______________________
Address: ______________________
Cell phone #: ______________________
Home phone #: ______________________
Other phone #: ______________________
Email address: ______________________
Relationship: ______________________

Support Needs – How long can applicant be without supervision?

☐ Up to 15 minutes ☐ Up to 1 hour ☐ All day

Please describe: ______________________________

Motor Skills – How frequently does applicants require support or assistance to walk and to stand?

☐ Rarely
☐ Often
☐ Sometimes
☐ Always

Please describe: ______________________________

Ambulation – Please check if the applicant uses a:

☐ Walker ☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Other

Please describe: ______________________________

Communication - What is the applicant's primary means of communication?

☐ Verbal speech
☐ Vocalization (sounds or few words)
☐ Gesture, Communication Board
☐ No speech
☐ Sign language

Please describe: ______________________________

Social and Communication Skills - How frequently does the applicant require help to get along with others?

☐ Rarely needs help
☐ Often needs help
☐ Sometimes needs help
☐ Always needs help

Please describe: ______________________________

Personal Living Skills – How frequently does the applicant require support with eating, dressing, using the bathroom, or personal hygiene?

☐ Rarely
☐ Often
☐ Sometimes
☐ Always

Please describe: ______________________________

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

☐ Rarely
☐ Often
☐ Sometimes
☐ Always

Please describe: ______________________________

Engagement – How often does the applicant need support engaging with community members?

☐ Rarely
☐ Often
☐ Sometimes
☐ Always

Please describe: ______________________________

Advocacy – How often can the applicant advocate for him/herself?

☐ Rarely
☐ Often
☐ Sometimes
☐ Always

Please describe: ______________________________

Criminal History

Have you ever been convicted of a crime? ☐ Yes ☐ No

If yes, please describe: ______________________________

Behavioral Supports – Have any behavioral supports proven successful for the applicant?

Please describe: ______________________________

Social and Developmental Summary

Please describe the applicant's pervious service history (e.g., services received; provider of services, dates of services:

____

Support Needs - Please describe the applicant's support needs (e.g., individual service needs, skill building goals, mental health needs):

____

____

Documentation of Need for Service - Please describe what the applicant and/or authorized representative hope to gain by participating in the program:

____

Family Summary

Father

Name: ______________________________

Address: ______________________________

Cell phone #: ______________________________

Home phone #: ______________________________

Other phone #: ______________________________

Email address: ______________________________

Mother

Name: ______________________________

Address: ______________________________

Cell phone #: ______________________________

Home phone #: ______________________________

Other phone #: ______________________________

Email address: ______________________________

Siblings (Names, ages and gender): ______________________________

____

____

Please describe the applicant's current family structure and relationships. Please describe the anticipated future involvement of the applicant's family:

____

____

Please describe other relatives' interest or involvement with the applicant:

____

____

Medical History

Please indicate if the applicant has any of the following medical conditions:

- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Back trouble
- ☐ Bipolar disorder
- ☐ Cerebral Palsy
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Gout
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ Hernia
- ☐ High blood pressure
- ☐ Indigestion
- ☐ Intellectual/Developmental Disability
- ☐ Kidney stones
- ☐ Low blood pressure
- ☐ Menstrual disorder
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Pleurisy
- ☐ Rheumatic fever
- ☐ Schizophrenia
- ☐ Sexually Transmitted Disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Varicose veins

Other medical conditions not listed: ______________________________

____

History of Seizures

☐ Under control with medication ☐ Under control without medication

Please describe: ______________________________

Other Health Matters

Please describe current significant medical problems, communicable diseases, or recent physical complaints of applicant:

____

____

Please describe past significant medical problems of applicant, serious injuries, serious illnesses or hospitalizations:

____

____

Please describe serious illnesses or chronic conditions of the applicant's parents, siblings and other relatives:

____

____

Please describe applicant's substance abuse history, if any, including the onset of use, types of substances, frequency of use, quantity of use, method of administrations:

____

____

Current Physician and Hospital Information:

Physician's Name: ______________________________
Practice Name: ______________________________
Address: ______________________________
Phone #: ______________________________
Preferred Hospital: ______________________________

Medications
Please attach a printed list of medications with the following information, if available.

- Medication Name
- Dosage
- Route
- Administration Times
- Reason for Drug
- Prescribing Doctor

Please list applicant's drug, food or other allergies:
____
____
____

Other Paperwork Needed from the Applicant or Case Manager:

- SIS (Supports Intensity Scale)
- VIDES (Virginia Individual Developmental Disabilities Eligibility Survey)
- Copy of Medicaid Card, if available
- Copy of Medicaid Card, if available
- Psychological Report
- Recent Physical, including general physical condition
- Evaluation for communicable diseases, including date of exam and signature of physician

Form completed by: ______________________________
Relationship to applicant: ______________________________
Date: ______________________________