Application for Services

(Please print or type)

Date of Application: _____

Check program(s) for which application is being submitted:

___ Supported Employment
___ Day Habilitation
___ Individual Support Services
___ Community Supported Living Arrangements

Applicant's General Information:

Applicant's Name:_____
Last First Middle Called By

Current Address:_____
Street City State Zip

Contact #:_____
Day Home Cell Email

Social Security Number:_____Date/Place of Birth:_____

Medicaid/Medical Assistance Number: _____ Other: _____

Service Coordinator: _____
Name Phone Number

Does Applicant have a Legal Guardian? _____Yes _____No

If YES, Name, Address, & Phone # of Legal Guardian:_____

_____

_____

Date Guardianship was attained: _____

Type of Guardianship (check whichever is applicable): ___ Full ___ Property
___ Limited ___ Medical

Caregiver Information:

1. Name: _____ Relationship to Applicant: _____

Address:_____
Street City State Zip

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Applicant Lives With (address same as Applicant's address):

2. Name: _____ Relationship to Applicant: _____

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Parent Information:

Father's
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased -- if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Mother's (Maiden)
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased --if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Siblings (Use of back of application for additional names)**:**

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #:_____

Applicant's Financial Information:

Applicant's Medicaid (Medical Assistance) #:_____

Applicant's Medicare #:_____

Other Medical Insurance (Please specify company name and policy #):

_____

_____

Name of Representative Payee (if different from Applicant):_____

SSA Amount: _____ SSI Amount_____

Medical Information:

A. Applicant's Primary Health Care Provider/Physician:_____

   Address: _____

   Phone Number: _____ Fax Number: _____

   Date of Last Physical Exam including TB Test (Copy must accompany Application):_____

   Examined By: _____

B. Diagnosis

Primary: _____

Secondary: _____

Tertiary: _____

Age of Onset: _____

C. List any medications taken by Applicant:

Medication	Dosage	Frequency	Reason

D. Seizures

1. Does the Applicant have seizures? ___ Yes ___ No
2. Frequency? ___Daily ___Weekly ___At Least Once a Month ___Every Few Months

   ___Other (please specify): _____
3. Type/Description of Seizure:_____
4. Are seizures controlled by medication? ___ Yes ___ No

E. Applicant's Mobility

___ Walks Independently ___ Uses Cane ___ Uses Walker ___ Uses Crutches

___ Uses Wheelchair ___ Manual ___ Electric

F. Vision

1. Any vision impairment? ___ Yes ___No
2. Does Applicant wear glasses or contact lenses? ___ Yes ___ No
3. Date of last eye examination: _____Legally Blind? ___ Yes ___ No

G. Hearing

1. Does the Applicant have a hearing problem? ___ Yes ___ No Explain: _____
2. Does the Applicant wear a hearing aid? ___ Yes ___ No
3. Date of last hearing examination: _____Deaf? ___ Yes ___ No

H. Dental

1. Date of last dental examination:_____ Dentures? ___ Yes ___ No
2. Brief description of any dental problems: _____

I. Speech and Language Information

1. Does the Applicant have any speech/language impairment? ___ Yes ___ No
2. Does the Applicant communicate verbally? ___ Yes ___ No
3. Has the Applicant had a speech/language assessment? ___ Yes ___ No
4. If yes, assessment done by: _____
5. Means of communication: ___ Speech ___ Sign Language ___ Gestures

   ___ Communication Board ___ Other (Describe)_____

J. Allergies (bee stings, drugs, dust, mold, food, etc.): _____

K. Does the Applicant have any implanted devices? If yes, please list:_____

_____

L. Does the Applicant have any other medical problems not listed above? If Yes, Please list:

_____

_____

_____

M. Does the Applicant have a history of alcohol or substance abuse? ___ Yes ___ No

List previous treatment and dates: _____

N. Has the Applicant ever been convicted of a crime? ___ Yes ___ No

Provide details:_____

_____

_____

O. Has the Applicant had any significant surgeries or hospitalizations?

_____

_____

_____

P. Does the Applicant have a special diet, use adaptive dishes/utensils, or need feeding assistance?

_____

_____

_____

Q. Does the Applicant: ____ Toilet independently ____ Wear adult protective undergarments

____Require staff assistance for personal care ____ Other (Please explain) _____

_____

Psychological Information:

A. Date of last psychological evaluation: _____

1. Performed by: _____

2. Address: _____

3. Diagnosis: _____

B. Has the Applicant received any mental health services? (i.e. counseling, out-patient or in-patient services) ___ Yes ___ No Describe: _____

C. Does the Applicant have a history of behavioral problems? ___ Yes ___ No (if yes, describe below)

Maladaptive Behavior	Frequency	Severity	Intervention

Does the Applicant have a behavior plan? ___ Yes ___ No (if yes, please explain below)

_____

_____

_____

Skills Checklist:

A. Is the Applicant independent in personal self-care skill? ___ Yes ___ No (If No, please explain)

_____

_____

_____

B. Can the Applicant self medicate? ___ Yes ___ No

C. Can the Applicant cross streets? ___ Independently ___ With assistance ___ No

D. Can the Applicant use mass transit? ___ Independently ___ With assistance ___ No

E. Can the Applicant remain at home unsupervised? ___ No ___ Yes, for _____ hours

F. Can the Applicant read? ___ No ___ Yes, at _____ level

G. Can the Applicant write? ___ No ___ Yes, at _____ level

H. What does the Applicant like to do with his/her free time?

_____

_____

_____

Background Information:

A. School(s) Attended Complete Address Dates Highest Grade Completed

_____

_____

_____

Contact person: _____

B. Adult/Vocational Program(s) Attended Complete Address Dates

_____

_____

_____

Contact person: _____

C. Residential Program Placement:

_____

_____

_____

Contact person: _____

D. Employment History:

Is the Applicant currently employed? ____Yes ____No

If yes, what is the employer's address?

_____

Phone#:_____ Supervisor's Name:_____

Job Title: _____ Start Date:_____ Wage:_____

Duties: _____

Previous Employment, list with most recent first (use additional paper if necessary):

1._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

2._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

If the Applicant is not currently employed, what are their job interests?

_____

_____

_____

Additional Team Members:

Does the Applicant have a current DORS Counselor? ____ No ____ Yes

If yes, please list name and phone number:_____

_____

Dose the Applicant have a current Social Worker? ____Yes ____No

If yes, please list name and phone number:_____

_____

Additional Information (completion is not required- The following information is used for statistical purposes only):
Religion: _____

Ethnic Identification (check as applicable): ___ Black ___ Caucasian ___ Hispanic

___ Asian ___ Native American ___ Other

U.S. Citizen? ___ Yes ___ No Sex: ___ Male ___ Female

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Language(s) spoken or understood: ___ English ___ Other, specify _____

Language(s) used in Applicant's home environment: ___ English ___ Other, specify _____

Signatures:

_____ _____
Signature of Applicant Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Signature of Person Completing the Form Date

ProvidenceCenter
Shaping Lives, Creating Futures.

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Medicaid/Medical Assistance Number: _____ Other: _____

Service Coordinator: _____
Name Phone Number

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Type of Guardianship (check whichever is applicable): ___ Full ___ Property
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Caregiver Information:

1. Name: _____ Relationship to Applicant: _____

Address:_____
Street City State Zip

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Applicant Lives With (address same as Applicant's address):

2. Name: _____ Relationship to Applicant: _____

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Parent Information:

Father's
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased -- if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Mother's (Maiden)
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased --if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Siblings (Use of back of application for additional names)**:**

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #:_____

Applicant's Financial Information:

Applicant's Medicaid (Medical Assistance) #:_____

Applicant's Medicare #:_____

Other Medical Insurance (Please specify company name and policy #):

_____

_____

Name of Representative Payee (if different from Applicant):_____

SSA Amount: _____ SSI Amount_____

Medical Information:

A. Applicant's Primary Health Care Provider/Physician:_____

   Address: _____

   Phone Number: _____ Fax Number: _____

   Date of Last Physical Exam including TB Test (Copy must accompany Application):_____

   Examined By: _____

B. Diagnosis

Primary: _____

Secondary: _____

Tertiary: _____

Age of Onset: _____

C. List any medications taken by Applicant:

Medication	Dosage	Frequency	Reason

D. Seizures

1. Does the Applicant have seizures? ___ Yes ___ No
2. Frequency? ___Daily ___Weekly ___At Least Once a Month ___Every Few Months

   ___Other (please specify): _____
3. Type/Description of Seizure:_____
4. Are seizures controlled by medication? ___ Yes ___ No

E. Applicant's Mobility

___ Walks Independently ___ Uses Cane ___ Uses Walker ___ Uses Crutches

___ Uses Wheelchair ___ Manual ___ Electric

F. Vision

1. Any vision impairment? ___ Yes ___No
2. Does Applicant wear glasses or contact lenses? ___ Yes ___ No
3. Date of last eye examination: _____Legally Blind? ___ Yes ___ No

G. Hearing

1. Does the Applicant have a hearing problem? ___ Yes ___ No Explain: _____
2. Does the Applicant wear a hearing aid? ___ Yes ___ No
3. Date of last hearing examination: _____Deaf? ___ Yes ___ No

H. Dental

1. Date of last dental examination:_____ Dentures? ___ Yes ___ No
2. Brief description of any dental problems: _____

I. Speech and Language Information

1. Does the Applicant have any speech/language impairment? ___ Yes ___ No
2. Does the Applicant communicate verbally? ___ Yes ___ No
3. Has the Applicant had a speech/language assessment? ___ Yes ___ No
4. If yes, assessment done by: _____
5. Means of communication: ___ Speech ___ Sign Language ___ Gestures

   ___ Communication Board ___ Other (Describe)_____

J. Allergies (bee stings, drugs, dust, mold, food, etc.): _____

K. Does the Applicant have any implanted devices? If yes, please list:_____

_____

L. Does the Applicant have any other medical problems not listed above? If Yes, Please list:

_____

_____

_____

M. Does the Applicant have a history of alcohol or substance abuse? ___ Yes ___ No

List previous treatment and dates: _____

N. Has the Applicant ever been convicted of a crime? ___ Yes ___ No

Provide details:_____

_____

_____

O. Has the Applicant had any significant surgeries or hospitalizations?

_____

_____

_____

P. Does the Applicant have a special diet, use adaptive dishes/utensils, or need feeding assistance?

_____

_____

_____

Q. Does the Applicant: ____ Toilet independently ____ Wear adult protective undergarments

____Require staff assistance for personal care ____ Other (Please explain) _____

_____

Psychological Information:

A. Date of last psychological evaluation: _____

1. Performed by: _____

2. Address: _____

3. Diagnosis: _____

B. Has the Applicant received any mental health services? (i.e. counseling, out-patient or in-patient services) ___ Yes ___ No Describe: _____

C. Does the Applicant have a history of behavioral problems? ___ Yes ___ No (if yes, describe below)

Maladaptive Behavior	Frequency	Severity	Intervention

Does the Applicant have a behavior plan? ___ Yes ___ No (if yes, please explain below)

_____

_____

_____

Skills Checklist:

A. Is the Applicant independent in personal self-care skill? ___ Yes ___ No (If No, please explain)

_____

_____

_____

B. Can the Applicant self medicate? ___ Yes ___ No

C. Can the Applicant cross streets? ___ Independently ___ With assistance ___ No

D. Can the Applicant use mass transit? ___ Independently ___ With assistance ___ No

E. Can the Applicant remain at home unsupervised? ___ No ___ Yes, for _____ hours

F. Can the Applicant read? ___ No ___ Yes, at _____ level

G. Can the Applicant write? ___ No ___ Yes, at _____ level

H. What does the Applicant like to do with his/her free time?

_____

_____

_____

Background Information:

A. School(s) Attended Complete Address Dates Highest Grade Completed

_____

_____

_____

Contact person: _____

B. Adult/Vocational Program(s) Attended Complete Address Dates

_____

_____

_____

Contact person: _____

C. Residential Program Placement:

_____

_____

_____

Contact person: _____

D. Employment History:

Is the Applicant currently employed? ____Yes ____No

If yes, what is the employer's address?

_____

Phone#:_____ Supervisor's Name:_____

Job Title: _____ Start Date:_____ Wage:_____

Duties: _____

Previous Employment, list with most recent first (use additional paper if necessary):

1._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

2._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

If the Applicant is not currently employed, what are their job interests?

_____

_____

_____

Additional Team Members:

Does the Applicant have a current DORS Counselor? ____ No ____ Yes

If yes, please list name and phone number:_____

_____

Dose the Applicant have a current Social Worker? ____Yes ____No

If yes, please list name and phone number:_____

_____

Additional Information (completion is not required- The following information is used for statistical purposes only):
Religion: _____

Ethnic Identification (check as applicable): ___ Black ___ Caucasian ___ Hispanic

___ Asian ___ Native American ___ Other

U.S. Citizen? ___ Yes ___ No Sex: ___ Male ___ Female

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Language(s) spoken or understood: ___ English ___ Other, specify _____

Language(s) used in Applicant's home environment: ___ English ___ Other, specify _____

Signatures:

_____ _____
Signature of Applicant Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Signature of Person Completing the Form Date

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Application for Services

(Please print or type)

Date of Application: _____

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Applicant's General Information:

Applicant's Name:_____
Last First Middle Called By

Current Address:_____
Street City State Zip

Contact #:_____
Day Home Cell Email

Social Security Number:_____Date/Place of Birth:_____

Medicaid/Medical Assistance Number: _____ Other: _____

Service Coordinator: _____
Name Phone Number

Does Applicant have a Legal Guardian? _____Yes _____No

If YES, Name, Address, & Phone # of Legal Guardian:_____

_____

_____

Date Guardianship was attained: _____

Type of Guardianship (check whichever is applicable): ___ Full ___ Property
___ Limited ___ Medical

Caregiver Information:

1. Name: _____ Relationship to Applicant: _____

Address:_____
Street City State Zip

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Applicant Lives With (address same as Applicant's address):

2. Name: _____ Relationship to Applicant: _____

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Parent Information:

Father's
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased -- if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Mother's (Maiden)
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased --if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Siblings (Use of back of application for additional names)**:**

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #:_____

Applicant's Financial Information:

Applicant's Medicaid (Medical Assistance) #:_____

Applicant's Medicare #:_____

Other Medical Insurance (Please specify company name and policy #):

_____

_____

Name of Representative Payee (if different from Applicant):_____

SSA Amount: _____ SSI Amount_____

Medical Information:

A. Applicant's Primary Health Care Provider/Physician:_____

   Address: _____

   Phone Number: _____ Fax Number: _____

   Date of Last Physical Exam including TB Test (Copy must accompany Application):_____

   Examined By: _____

B. Diagnosis

Primary: _____

Secondary: _____

Tertiary: _____

Age of Onset: _____

C. List any medications taken by Applicant:

Medication	Dosage	Frequency	Reason

D. Seizures

1. Does the Applicant have seizures? ___ Yes ___ No
2. Frequency? ___Daily ___Weekly ___At Least Once a Month ___Every Few Months

   ___Other (please specify): _____
3. Type/Description of Seizure:_____
4. Are seizures controlled by medication? ___ Yes ___ No

E. Applicant's Mobility

___ Walks Independently ___ Uses Cane ___ Uses Walker ___ Uses Crutches

___ Uses Wheelchair ___ Manual ___ Electric

F. Vision

1. Any vision impairment? ___ Yes ___No
2. Does Applicant wear glasses or contact lenses? ___ Yes ___ No
3. Date of last eye examination: _____Legally Blind? ___ Yes ___ No

G. Hearing

1. Does the Applicant have a hearing problem? ___ Yes ___ No Explain: _____
2. Does the Applicant wear a hearing aid? ___ Yes ___ No
3. Date of last hearing examination: _____Deaf? ___ Yes ___ No

H. Dental

1. Date of last dental examination:_____ Dentures? ___ Yes ___ No
2. Brief description of any dental problems: _____

I. Speech and Language Information

1. Does the Applicant have any speech/language impairment? ___ Yes ___ No
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4. If yes, assessment done by: _____
5. Means of communication: ___ Speech ___ Sign Language ___ Gestures

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J. Allergies (bee stings, drugs, dust, mold, food, etc.): _____

K. Does the Applicant have any implanted devices? If yes, please list:_____

_____

L. Does the Applicant have any other medical problems not listed above? If Yes, Please list:

_____

_____

_____

M. Does the Applicant have a history of alcohol or substance abuse? ___ Yes ___ No

List previous treatment and dates: _____

N. Has the Applicant ever been convicted of a crime? ___ Yes ___ No

Provide details:_____

_____

_____

O. Has the Applicant had any significant surgeries or hospitalizations?

_____

_____

_____

P. Does the Applicant have a special diet, use adaptive dishes/utensils, or need feeding assistance?

_____

_____

_____

Q. Does the Applicant: ____ Toilet independently ____ Wear adult protective undergarments

____Require staff assistance for personal care ____ Other (Please explain) _____

_____

Psychological Information:

A. Date of last psychological evaluation: _____

1. Performed by: _____

2. Address: _____

3. Diagnosis: _____

B. Has the Applicant received any mental health services? (i.e. counseling, out-patient or in-patient services) ___ Yes ___ No Describe: _____

C. Does the Applicant have a history of behavioral problems? ___ Yes ___ No (if yes, describe below)

Maladaptive Behavior	Frequency	Severity	Intervention

Does the Applicant have a behavior plan? ___ Yes ___ No (if yes, please explain below)

_____

_____

_____

Skills Checklist:

A. Is the Applicant independent in personal self-care skill? ___ Yes ___ No (If No, please explain)

_____

_____

_____

B. Can the Applicant self medicate? ___ Yes ___ No

C. Can the Applicant cross streets? ___ Independently ___ With assistance ___ No

D. Can the Applicant use mass transit? ___ Independently ___ With assistance ___ No

E. Can the Applicant remain at home unsupervised? ___ No ___ Yes, for _____ hours

F. Can the Applicant read? ___ No ___ Yes, at _____ level

G. Can the Applicant write? ___ No ___ Yes, at _____ level

H. What does the Applicant like to do with his/her free time?

_____

_____

_____

Background Information:

A. School(s) Attended Complete Address Dates Highest Grade Completed

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_____

_____

Contact person: _____

B. Adult/Vocational Program(s) Attended Complete Address Dates

_____

_____

_____

Contact person: _____

C. Residential Program Placement:

_____

_____

_____

Contact person: _____

D. Employment History:

Is the Applicant currently employed? ____Yes ____No

If yes, what is the employer's address?

_____

Phone#:_____ Supervisor's Name:_____

Job Title: _____ Start Date:_____ Wage:_____

Duties: _____

Previous Employment, list with most recent first (use additional paper if necessary):

1._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

2._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

If the Applicant is not currently employed, what are their job interests?

_____

_____

_____

Additional Team Members:

Does the Applicant have a current DORS Counselor? ____ No ____ Yes

If yes, please list name and phone number:_____

_____

Dose the Applicant have a current Social Worker? ____Yes ____No

If yes, please list name and phone number:_____

_____

Additional Information (completion is not required- The following information is used for statistical purposes only):
Religion: _____

Ethnic Identification (check as applicable): ___ Black ___ Caucasian ___ Hispanic

___ Asian ___ Native American ___ Other

U.S. Citizen? ___ Yes ___ No Sex: ___ Male ___ Female

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Language(s) spoken or understood: ___ English ___ Other, specify _____

Language(s) used in Applicant's home environment: ___ English ___ Other, specify _____

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_____ _____
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_____ _____
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What's the best way and time to reach you?_____

Applicant Lives With (address same as Applicant's address):

2. Name: _____ Relationship to Applicant: _____

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Parent Information:

Father's
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased -- if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Mother's (Maiden)
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

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Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #:_____

Applicant's Financial Information:

Applicant's Medicaid (Medical Assistance) #:_____

Applicant's Medicare #:_____

Other Medical Insurance (Please specify company name and policy #):

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___ Uses Wheelchair ___ Manual ___ Electric

F. Vision

1. Any vision impairment? ___ Yes ___No
2. Does Applicant wear glasses or contact lenses? ___ Yes ___ No
3. Date of last eye examination: _____Legally Blind? ___ Yes ___ No

G. Hearing

1. Does the Applicant have a hearing problem? ___ Yes ___ No Explain: _____
2. Does the Applicant wear a hearing aid? ___ Yes ___ No
3. Date of last hearing examination: _____Deaf? ___ Yes ___ No

H. Dental

1. Date of last dental examination:_____ Dentures? ___ Yes ___ No
2. Brief description of any dental problems: _____

I. Speech and Language Information

1. Does the Applicant have any speech/language impairment? ___ Yes ___ No
2. Does the Applicant communicate verbally? ___ Yes ___ No
3. Has the Applicant had a speech/language assessment? ___ Yes ___ No
4. If yes, assessment done by: _____
5. Means of communication: ___ Speech ___ Sign Language ___ Gestures

   ___ Communication Board ___ Other (Describe)_____

J. Allergies (bee stings, drugs, dust, mold, food, etc.): _____

K. Does the Applicant have any implanted devices? If yes, please list:_____

_____

L. Does the Applicant have any other medical problems not listed above? If Yes, Please list:

_____

_____

_____

M. Does the Applicant have a history of alcohol or substance abuse? ___ Yes ___ No

List previous treatment and dates: _____

N. Has the Applicant ever been convicted of a crime? ___ Yes ___ No

Provide details:_____

_____

_____

O. Has the Applicant had any significant surgeries or hospitalizations?

_____

_____

_____

P. Does the Applicant have a special diet, use adaptive dishes/utensils, or need feeding assistance?

_____

_____

_____

Q. Does the Applicant: ____ Toilet independently ____ Wear adult protective undergarments

____Require staff assistance for personal care ____ Other (Please explain) _____

_____

Psychological Information:

A. Date of last psychological evaluation: _____

1. Performed by: _____

2. Address: _____

3. Diagnosis: _____

B. Has the Applicant received any mental health services? (i.e. counseling, out-patient or in-patient services) ___ Yes ___ No Describe: _____

C. Does the Applicant have a history of behavioral problems? ___ Yes ___ No (if yes, describe below)

Maladaptive Behavior	Frequency	Severity	Intervention

Does the Applicant have a behavior plan? ___ Yes ___ No (if yes, please explain below)

_____

_____

_____

Skills Checklist:

A. Is the Applicant independent in personal self-care skill? ___ Yes ___ No (If No, please explain)

_____

_____

_____

B. Can the Applicant self medicate? ___ Yes ___ No

C. Can the Applicant cross streets? ___ Independently ___ With assistance ___ No

D. Can the Applicant use mass transit? ___ Independently ___ With assistance ___ No

E. Can the Applicant remain at home unsupervised? ___ No ___ Yes, for _____ hours

F. Can the Applicant read? ___ No ___ Yes, at _____ level

G. Can the Applicant write? ___ No ___ Yes, at _____ level

H. What does the Applicant like to do with his/her free time?

_____

_____

_____

Background Information:

A. School(s) Attended Complete Address Dates Highest Grade Completed

_____

_____

_____

Contact person: _____

B. Adult/Vocational Program(s) Attended Complete Address Dates

_____

_____

_____

Contact person: _____

C. Residential Program Placement:

_____

_____

_____

Contact person: _____

D. Employment History:

Is the Applicant currently employed? ____Yes ____No

If yes, what is the employer's address?

_____

Phone#:_____ Supervisor's Name:_____

Job Title: _____ Start Date:_____ Wage:_____

Duties: _____

Previous Employment, list with most recent first (use additional paper if necessary):

1._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

2._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

If the Applicant is not currently employed, what are their job interests?

_____

_____

_____

Additional Team Members:

Does the Applicant have a current DORS Counselor? ____ No ____ Yes

If yes, please list name and phone number:_____

_____

Dose the Applicant have a current Social Worker? ____Yes ____No

If yes, please list name and phone number:_____

_____

Additional Information (completion is not required- The following information is used for statistical purposes only):
Religion: _____

Ethnic Identification (check as applicable): ___ Black ___ Caucasian ___ Hispanic

___ Asian ___ Native American ___ Other

U.S. Citizen? ___ Yes ___ No Sex: ___ Male ___ Female

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Language(s) spoken or understood: ___ English ___ Other, specify _____

Language(s) used in Applicant's home environment: ___ English ___ Other, specify _____

Signatures:

_____ _____
Signature of Applicant Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Signature of Person Completing the Form Date

ProvidenceCenter
Shaping Lives, Creating Futures.

Application for Services

(Please print or type)

Date of Application: _____

Check program(s) for which application is being submitted:

___ Supported Employment
___ Day Habilitation
___ Individual Support Services
___ Community Supported Living Arrangements

Applicant's General Information:

Applicant's Name:_____
Last First Middle Called By

Current Address:_____
Street City State Zip

Contact #:_____
Day Home Cell Email

Social Security Number:_____Date/Place of Birth:_____

Medicaid/Medical Assistance Number: _____ Other: _____

Service Coordinator: _____
Name Phone Number

Does Applicant have a Legal Guardian? _____Yes _____No

If YES, Name, Address, & Phone # of Legal Guardian:_____

_____

_____

Date Guardianship was attained: _____

Type of Guardianship (check whichever is applicable): ___ Full ___ Property
___ Limited ___ Medical

Caregiver Information:

1. Name: _____ Relationship to Applicant: _____

Address:_____
Street City State Zip

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Applicant Lives With (address same as Applicant's address):

2. Name: _____ Relationship to Applicant: _____

Contact #:_____
Day Home Cell Email

What's the best way and time to reach you?_____

Parent Information:

Father's
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased -- if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Mother's (Maiden)
Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Occupation: _____

Work Phone: _____

Living/Deceased --if deceased, please give

date: _____

Place of Birth: _____

Marital Status: _____

Siblings (Use of back of application for additional names)**:**

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #:_____

Applicant's Financial Information:

Applicant's Medicaid (Medical Assistance) #:_____

Applicant's Medicare #:_____

Other Medical Insurance (Please specify company name and policy #):

_____

_____

Name of Representative Payee (if different from Applicant):_____

SSA Amount: _____ SSI Amount_____

Medical Information:

A. Applicant's Primary Health Care Provider/Physician:_____

   Address: _____

   Phone Number: _____ Fax Number: _____

   Date of Last Physical Exam including TB Test (Copy must accompany Application):_____

   Examined By: _____

B. Diagnosis

Primary: _____

Secondary: _____

Tertiary: _____

Age of Onset: _____

C. List any medications taken by Applicant:

Medication	Dosage	Frequency	Reason

D. Seizures

1. Does the Applicant have seizures? ___ Yes ___ No
2. Frequency? ___Daily ___Weekly ___At Least Once a Month ___Every Few Months

   ___Other (please specify): _____
3. Type/Description of Seizure:_____
4. Are seizures controlled by medication? ___ Yes ___ No

E. Applicant's Mobility

___ Walks Independently ___ Uses Cane ___ Uses Walker ___ Uses Crutches

___ Uses Wheelchair ___ Manual ___ Electric

F. Vision

1. Any vision impairment? ___ Yes ___No
2. Does Applicant wear glasses or contact lenses? ___ Yes ___ No
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Maladaptive Behavior	Frequency	Severity	Intervention

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_____

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_____

Contact person: _____

B. Adult/Vocational Program(s) Attended Complete Address Dates

_____

_____

_____

Contact person: _____

C. Residential Program Placement:

_____

_____

_____

Contact person: _____

D. Employment History:

Is the Applicant currently employed? ____Yes ____No

If yes, what is the employer's address?

_____

Phone#:_____ Supervisor's Name:_____

Job Title: _____ Start Date:_____ Wage:_____

Duties: _____

Previous Employment, list with most recent first (use additional paper if necessary):

1._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

2._____

Company Name

_____

Company Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

If the Applicant is not currently employed, what are their job interests?

_____

_____

_____

Additional Team Members:

Does the Applicant have a current DORS Counselor? ____ No ____ Yes

If yes, please list name and phone number:_____

_____

Dose the Applicant have a current Social Worker? ____Yes ____No

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_____

Additional Information (completion is not required- The following information is used for statistical purposes only):
Religion: _____

Ethnic Identification (check as applicable): ___ Black ___ Caucasian ___ Hispanic

___ Asian ___ Native American ___ Other

U.S. Citizen? ___ Yes ___ No Sex: ___ Male ___ Female

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Language(s) spoken or understood: ___ English ___ Other, specify _____

Language(s) used in Applicant's home environment: ___ English ___ Other, specify _____

Signatures:

_____ _____
Signature of Applicant Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Signature of Person Completing the Form Date

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