Application for Services

PARTICIPANT (full name) _____ Nickname _____

Birthdate ___/___/___ SS# ___-___-___ Religion _____

Address where participant lives _____

Phone _____ Participant Cell (if applicable) _____

Contact name where participant lives _____ Relationship _____

Cell Phone _____ Work Phone _____ Email _____

Residential Company _____

Contact _____ Phone _____

Does the participant have a *legally appointed* guardian? ☐ Yes ☐ No

If yes, Guardian Name _____

Date of Appointment _____ Docket # _____

Guardian Address _____

Guardian Phone _____ Email _____

Co-guardian name (if applicable) _____

Address _____

Phone _____ Email _____

PARENTS/PRIMARY CAREGIVER

Mother's Full Name _____

Address _____

Home Phone _____ Cell Phone _____

Employment _____ City _____ Phone _____

Father's Full Name _____

Address _____

Home Phone _____ Cell Phone _____

Employment _____ City _____ Phone _____

Emergency Contact Information

Who should we contact first in an emergency

Name _____ Relationship _____ Best Phone Number _____

Second emergency contact, if we are unable to reach any of the above

Name _____ Relationship _____ Best Phone Number _____

Hospital of Choice _____

Medicaid # _____ Medicare # _____ Other insurance _____

Additional Contacts

Other / Next of Kin

Name _____ Relationship _____ Best Phone Number _____

Physician Name _____ Phone _____

Address _____

Dentist Name _____ Phone _____

Address _____

Service Coordinator Name _____ Direct line _____

Area Agency _____

Medical/Health & Supervision Information

Primary Disability _____

_____

Medical Diagnosis (if applicable) _____

_____

Physical Disabilities (if applicable) _____

_____

Learning Disability (if applicable) _____

Mental Health Diagnosis (if applicable) _____

Other Disabilities or Issues _____

Other Relevant Medical Issues _____

Special Diet _____

Special hygiene Needs _____

Allergies _____

_____

Communication (check were applicable) ☐ Verbal ☐ Sign Language ☐ AAC device ☐ Other

Deaf ☐ Yes ☐ No

Supervision *pick one*
☐ Must be eyes-on at all times .
☐ Must know precise whereabouts.
☐ Has alone time up to: ☐ Minutes _____ ☐ Hours _____

Can participant be dropped off at home alone? ☐ Yes ☐ No

MEDICATIONS

Medications taken at home

Medication	Frequency/dose	Reason

Medications taken from 8 am to 4 pm

Medication	Frequency/dose	Reason

Physical Appearance

Sex _____ Race _____ Height _____ Weight _____

Hair _____ Distinguishing Marks _____

Immunizations

Dates of Hepatitis B _____ / _____ / _____

Date of last Tetnus _____

Referred By

Name _____

Date Form Completed _____ Completed By _____