

Date Received _____

Date Up-dated _____



APPLICATION

Name: First Middle Last	Other Names Used: First Last
Date of Birth:	Birth name:
Place of Birth:	Gender: Race: Hair color: Eye color:
Home address:	Height: Weight: Marital Status:
Home Phone:	Medicaid #: Plan:
Religious preference:	Social Security #
Parent Name: Address:	Distinguishing characteristics:
Phone #:	
Parent, next of kin: Address:	Guardian: Address:
Phone #	Phone # (Please attach copy of court order)
Emergency Contact: Phone:	Social Security Amount Claim # Payee
Primary Doctor: Phone:	Medicare # Type A Type A & B
Dentist: Phone:	SSI Amount Payee
Specialist: Phone :	Other Medical Insurance: Policy #:
Specialist: Phone:	Funeral Plan:
Specialist: Phone:	Life Insurance:
List of allergies:	Trust: Trustee:
General Medical History:	
Medication and other pertinent information:	

OTHER FAMILY MEMBERS AND/OR CONTACTS

Name	Relationship	Address	Phone #

OTHER AGENCIES INVOLVED

Agency Name	Contact Person	Phone #

Office Use Only:

EDUCATIONAL HISTORY

Name & Location of Schools	School District	Type of Class	Dates Attended

OCCUPATIONAL HISTORY

Include employment, workshops and activity centers

Employer/Address	Phone	Type of Work/Agency	Dates

RESIDENTIAL HISTORY

Name of Facility/Type of Living Situation	Address	Dates (To-From)	Court Mandated

COMMUNITY MOBILITY

Does applicant use public transportation?	If not, why not?
Does applicant have street crossing skills?	Bus? RideSource?
Could applicant be taught to use public transportation?	

Applicant's strengths, capabilities, interests, hobbies:

Check those which apply to applicant: NA-N/A MI-mild MO-moderate SE-severe SU-suspected

	NA	MI	MO	SE	SU	Description
Autism						
Behavior Dysfunction						
Cerebral Palsy						
Communication Dysfunction						
Emotional Problems						
Fine Motor Dysfunction						
Gross Motor Dysfunction						
Hearing Dysfunction						
Mental Illness						
Mental Retardation						
Seizures/Epilepsy						
Visual Dysfunction						

Other Health Problems:
(e.g. incontinence, special equipment, etc.)

Equipment used (please be specific):

MAJOR MEDICAL OCCURRENCES

Major Illness	Year	Major Injuries	Year	Major Operations	Year

Is applicant presently receiving psychiatric services?		
Has applicant received psychological/psychiatric services in the past?		
Psychiatrist/Counselor Name:	Address:	Phone:
Length of time in services:	Type/Frequency:	

Does applicant have any serious behavior problems? Yes [] No []					
Please check below any that apply to applicant:					
Threatens physical harm to others		Damages property		Defies authority	
Does physical harm		Has temper tantrums		Runs away	
Threatens physical harm to self		Displays inappropriate sexual behavior		Is severely withdrawn	
Does physical harm to self		Steals		Is hyperactive	
Attempts or threatens suicide		Attempts or commits arson		Deliberately provokes others	

Please describe checked items, and any other inappropriate behaviors exhibited by the applicant, giving details of how each has been a problem and what has been done to try to change these behaviors and what the results have been. Include behavior modification programs attempted.

Does applicant have a court record?	Where?
Offenses:	
Services or conditions mandated by the court:	

