

Date of Application: _____

Application for Students Transitioning into Adult Services

APPLICANT'S INFORMATION

Name: _____
Last First Middle

Date of Birth: ____/____/____ Medicaid/Medical Assistance #: _____

Current Address: _____
Street City State Zip

Permanent Address: _____
Street City State Zip

Telephone #: _____ Social Security #: _____

Ethnic Identification (completion is not required):

African American Caucasian Hispanic Native American Asian

Other: _____ Sex: MALE FEMALE U.S. Citizen? YES NO

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

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

Language(s) spoken in applicant's home: English Other, specify: _____

EMERGENCY CONTACTS (use additional paper if necessary)

Name: _____ Relationship to Applicant: _____

Address: _____ Best way to contact?: _____

Telephone #: _____ Cell/Work #: _____

Name: _____ Relationship to Applicant: _____

Address: _____ Best way to contact?: _____

Telephone #: _____ Cell/Work #: _____

GUARDIAN/CAREGIVER INFORMATION

Name: _____ Relationship to Applicant: _____

Address: _____

Telephone #: _____ Cell/Work #: _____

E-mail Address: _____

What is the best way and time to reach you?: _____

LIVING SITUATION (please include names)

Parents: _____ Guardians or Relatives: _____

Foster Home: _____ Other: _____

Address: _____

Phone #: _____ Legal Guardian: _____

Date Guardianship was attained: _____ Number of occupants living in the home: _____

Type of Guardianship (check which applies):

- Full Property Limited Medical Person

FAMILY INFORMATION

Parent Information:

	Father	Mother
Name		
Address		
Home Phone		
Cell Phone		
Business Phone		
Date of Birth		
Deceased (yes/no)		
Date of Death		

Siblings/Other Family Members Living in the Household (use additional paper if necessary):

Name			
Address			
Phone			
Relationship to Applicant			
Date of Birth			

FINANCIAL INFORMATION (Complete only if seeking residential services)

SSI Claim #: _____ SSI Amount: _____

SSA Claim #: _____ SSA Amount: _____

Name of representative payee/relationship to applicant: _____

Other sources of Applicants Income: _____

Account Types: CHECKING SAVINGS Bank Name: _____

Property in applicant's name (list location and value): _____

Trust Fund: YES NO Type: _____

If yes, give name and address of trustee: _____

MEDICAL INFORMATION

A. Diagnoses:

Primary Diagnosis: _____

Additional Diagnosis: _____

Additional Diagnosis: _____

B. Medications (use additional paper if necessary):

Medication	Dosage	Frequency	Reason

C. Insurance Information:

Applicants Medicaid/Medical Assistance #: _____

Dates Covered under Medicaid/Medical Assistance: _____

Applicants Medicare #: _____ Type: _____

Other Medical Insurance (list company name and policy #): _____

D. Physician and Dentist Information:

Applicant's Primary Physician: _____

Address: _____

Phone #: _____

Hospital familiar with Applicant: _____

Applicant's Dentist: _____

Address: _____

Phone #: _____ Does the applicant wear dentures? YES NO

Briefly list any dental problem(s): _____

E. Vision and Hearing:

Does the applicant have a vision impairment? YES NO

Is the applicant legally blind? YES NO

Does the applicant wear: Glasses Reading Glasses Contact Lenses

Does the applicant have a hearing impairment? YES NO

Does the applicant wear a hearing aid? YES NO

Is the applicant deaf? YES NO

F. Seizures:

Does the applicant have seizures? YES NO Frequency: _____

Type: _____ Are seizures controlled by medication? YES NO

G. Speech and Language:

Does the applicant have a speech or language impairment? YES NO

Is the applicant verbal? YES NO

Has the applicant had a speech/language assessment? YES NO

Assessment completed by: _____ Date of Assessment: _____

Applicant means of communication:

Speech Sign Language Gestures Communication Board

H. Mobility:

Walks Independently Uses Canes Uses Crutches Uses Walker

Uses Wheelchair Type: _____

Can the wheelchair user: Transfer Independently Needs Assistance

Can the applicant cross streets? Independently With Assistance No

Can the applicant use mass transit? Independently With Assistance No

Is the applicant certified to use Paratransit/MTA Mobility?: YES NO

Does the applicant have an MTA bus pass?: YES NO Type?: _____

I. Other:

Does the applicant have any other medical conditions not listed above?

Has the applicant had any significant surgeries or hospitalizations?

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

Does the applicant have any allergies (environmental, medication, foods, etc.)?

Does the applicant: Use the bathroom independently Wear diapers
 Need transfer assistance to the toilet

MENTAL HEALTH / PSYCHOLOGICAL

Applicant's Current Psychiatrist: _____

Address: _____

Phone #: _____

Applicant's Current Psychologist: _____

Address: _____

Phone #: _____

Applicant's Current Therapist: _____

Address: _____

Phone #: _____

Does the applicant have a history of behavioral problems? YES NO

Does the applicant have a current behavior plan in school? YES NO

If yes, please briefly explain below (use additional paper if necessary): _____

EDUCATION

Schools or Adult Programs Attended (use additional paper if necessary):

Program	Address	Dates Attended

Vocational Programs or Trainings Attended (use additional paper if necessary):

Program	Address	Dates Attended

SKILLS

1. Is the applicant independent in personal self-care skills? YES NO
(e.g. bathing, dressing, feeding, toileting)

2. Can the applicant self-medicate? YES NO

3. Is the applicant capable of remaining home unsupervised? YES NO
If yes, for how long: _____

4. Can the applicant read? YES NO If yes, what level: _____

5. Can the applicant write? YES NO If yes, what level: _____

6. Does the applicant sleep through the night? YES NO

7. What time does the applicant usually go to bed? _____ Get up in the morning? _____

8. What does the applicant like to do with his/her free time? _____

9. Please provide a brief description of the applicants daily routine: _____

10. Has the applicant received or is the applicant currently receiving any types of services or financial assistance (i.e. Rolling Access funds, respite Services, In-Home Support Services, Foster Care, etc.)? If yes, please list below:

EMPLOYMENT

Is the applicant currently employed? YES NO

If yes, what is the employment address: _____

Phone #: _____ Supervisor's Name: _____

Job Title: _____ Start date: _____ Wage: _____

Duties: _____

Previous Employment (use additional paper if necessary):

Company Name Company Address Company Phone #

Job Title Supervisor's Name Dates Employed

Company Name Company Address Company Phone #

Job Title Supervisor's Name Dates Employed

Company Name Company Address Company Phone #

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 Service Coordinator? YES NO

If yes please state name and phone number: _____

Does the applicant have a current DORS Counselor? YES NO

If yes please state name and phone number: _____

Does the applicant have a current Social Worker? YES NO

If yes please state name and phone number: _____

SIGNATURES

Signature of Applicant (if over 18 year old)

Date

Signature of parent/guardian (if applicable)

Date

Signature of Person Completing the Form

Date

FOR OFFICE USE ONLY

Date application was received: _____

Critical needs list: YES NO

Level of services approved:

- Day Habilitation
- Residential
- In-Home Support Services
- Vocational
- Medical Day Habilitation

Comments/Notes: _____

