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 #: _____

Date of Application: _____

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		

Date of Application: _____

Deceased (yes/no)		
Date of Death		

Date of Application: _____

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:

Date of Application: _____

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?

_____

Date of Application: _____

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: _____

_____

Date of Application: _____

_____

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

Date of Application: _____

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

Date of Application: _____

Comments/Notes: _____

_____

_____