

## **DAY SUPPORT PROGRAM APPLICATION**

### **I. INTRODUCTORY DATA**

Consumer Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Gender M \_\_\_ F \_\_\_

Social Security # \_\_\_\_\_ Medicaid # \_\_\_\_\_ Medicare# \_\_\_\_\_

Social Security Disability Insurance (SSDI) \_\_\_\_\_

Supplemental Security Insurance (SSI) \_\_\_\_\_

Other Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Source of Referral \_\_\_\_\_

Reason for Referral \_\_\_\_\_

Level of Intellectual Disability \_\_\_\_\_

Other/Secondary Disabilities \_\_\_\_\_

Marital Status \_\_\_\_\_ Citizenship Status \_\_\_\_\_

Race \_\_\_\_\_ Date of Birth \_\_\_\_\_

Criminal Justice Status \_\_\_\_\_

Legal Guardian (Court Appointed) \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Primary Language \_\_\_\_\_ Secondary Language \_\_\_\_\_

**II. SOCIAL/DEVELOPMENTAL DATA**

**Family Composition**

Father \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Mother \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Siblings \_\_\_\_\_

\_\_\_\_\_

**Other Significant Support Systems**

\_\_\_\_\_

\_\_\_\_\_

**Emergency Contacts (please indicate two)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

**III. LEVELS OF SUPPORT REQUIRED**

Behavioral/Emotional \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Communication/Social \_\_\_\_\_

\_\_\_\_\_

Medical \_\_\_\_\_

\_\_\_\_\_

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Personal Care \_\_\_\_\_

\_\_\_\_\_

Interests/Preferences \_\_\_\_\_

\_\_\_\_\_

Describe any other concerns or issues that may affect participation in day support program:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IV. CONTACTS**

1. **Social Worker/Case Manager** (Other Agency Involvement)

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

2. **Physician**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

3. **Dentist**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

4. **Other**

\_\_\_\_\_

Day Support Funding Source:

Medicaid Waiver \_\_\_\_\_ CSB \_\_\_\_\_ ICF/MR \_\_\_\_\_ Other \_\_\_\_\_

Person Completing Application \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_