Center for Social Change, Inc.

APPLICATION FOR SERVICES

(Please print or type)

Date of Application:

PLEASE CHECK PROGRAM(S) FOR WHICH APPLICATION IS BEING SUBMITTED. Please print clearly.

ADULT SERVICES:	**CHILDREN SERVICES**
☐ Employment and Vocational Services	☐ Children Residential (ALU/GH)
☐ Day Habilitation Services	
☐ Community Residential(ALU/GH)	
☐ Community Residential CSLA	
☐ FISS	

APPLICANT'S GENERAL INFORMATION

Individual's Last Name: First: Middle:	Birth Date:	Age:	Social Security Number:

Gender	☐ Male ☐ Female ☐ Transgender ☐ Gender Expression:_____ ☐ Other:_____	Home Phone Number: - - Cell Phone Number
Current Address:		

City:	County:	State:	ZIP Code:

PARENT/GUARDIAN/CAREGIVER INFORMATION:

Name:	Relationship to Applicant:	Phone:
Address:	City/State/Zip:	Cell Phone:

E-Mail Address:	May we send you information via e-mail? ☐ Yes ☐ NO

APPLICANT'S LIVING SITUATION (Please include names)

Parents:	Guardian or Relatives:
Foster Home:	Other:
Address:	
Phone Number:	Legal Guardian:
If Legal Guardian, please give date guardianship was attained:	Number of Occupants living in the home:

What type of guardianship? ☐ Full ☐ Property ☐ Limited ☐ Medical ☐ Person

* Guardianship documentation MUST be furnished at the time of admission.

FAMILY INFORMATION

FATHER		MOTHER	
Name:		Name:	
Birth Date:		Birth Date:	
Address:		Address:	
Home Phone:		Home Phone:	
Occupation:		Occupation:	
Work Phone:		Work Phone:	
Social Security No.:		Social Security No.:	
If deceased, give date:		If deceased, give date:	
Place of Birth:		Place of Birth:	
Marital Status:		Marital Status:	

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BROTHERS AND SISTERS(Use additional paper if necessary)

Name	Birth Date	Phone Number	Address	Occupation

OTHER FAMILY MEMBERS LIVING IN THE HOME (Use additional paper if necessary):

Name	Birth Date	Relation to Applicant	Phone Number	Occupation

CONFIDENTIAL INFORMATION

Social Security #:	Type of Income/Amount: (i.e., SSI/SSDI)
Other Sources of Income/Resources: (i.e., trust fund, insurance, property)	Representative Payee:
Medical Assistance #:	Medicare #:
Other Health Insurance:	Policy Number:

Does applicant have a Service Coordinator (or DSS Case Manager)? If so, please provide contact information:

Name:	Agency:	Phone Number:

APPLICANT'S FINANCIAL INFORMATION

SSI Claim #:	SSI Amount:
SSA Claim #:	SSA Amount:
Name of Wage Earner:	
Name of Representative Payee:	
V.A. Claim #:	V.A. Benefit Amount:
Name of Veteran:	
Railroad Retirement Claim Number:	
Name of Wage Earner:	Life Insurance Coverage:
Burial Plot Location:	
Estimated Value:	Type of Burial Plan:
Other Sources of Applicant's Income:	
Applicant's Bank Account:	Bank Name:
Any property in applicant's name (give location and value):	
Trust Fund: ☐ YES ☐ NO	Type:
If yes, give name and address of Trustee:	
Applicant's place of employment (name and address):	

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Applicant's monthly earnings from employment:

MEDICAL INFORMATION

A. Applicant's Primary Health Care Provider/Physician:

Address:	
Phone Number:	Date of Last Physical Exam:
Examined by:	Address:
Hospital familiar with applicant (if any):	

B. DIAGNOSIS

Primary:
Secondary:
Tertiary:
Age of Onset:

C. List of any medication(s) taken by Applicant:

MEDICATION		DOSAGE	REASON	

D. History of Hospitalizations

DATE	REASON		HOSPITAL	PHYSICIAN

E. Seizures

1. Does the applicant have seizures? ☐ YES ☐ NO				
2. Frequency:	☐ Daily	☐ Weekly	☐ At least once a month	☐ Every few months
3. Type of seizures:				
4. Are seizures controlled by medication? ☐ YES ☐ NO				

F. Applicant's Mobility

☐ Walks independently	☐ Uses cane	☐ Uses crutches	☐ Uses walker	
☐ Uses wheelchair ☐ YES ☐ NO		☐ Manual	☐ Electric	☐ Self-Propelled

G. Vision

1. Any vision impairment: ☐ YES ☐ NO
2. Does applicant wear glasses or contact lenses?

3. Date of last eye exam:		Legally Blind: ☐ YES ☐ NO
Doctor's Name:	Address:	Phone Number(s):

H. Hearing

1. Does applicant have hearing problem? ☐ YES ☐ NO

2. Does applicant wear a hearing aid? ☐ YES ☐ NO

3. Date of last hearing exam:		Deaf: ☐ YES ☐ NO
Doctor's Name:	Address:	Phone Number(s):

I. Dental

1. Date of last dental exam:		Dentures: ☐ YES ☐ NO
2. Brief description of any dental problem(s):		
Dentist's Name:	Address:	Phone Number(s):

J. Adaptive – Assistive Equipment Needed

☐ Hoyer Lift	☐ Bed Rails	☐ Need for Oxygen?	☐ Other Adaptive/Special Equipment:

K. Allergies (bee stings, drugs, dust, mold, food, latex, vapors, seasonal etc.):

☐ No Known Drug Allergies ☐ No known Food Allergies

L. Other

1. When was the Applicant's last tetanus shot?

2. Does applicant have any other medical problems, or special health care needs, not listed? If yes, please explain.

SPEECH AND LANGUAGE INFORMATION

1. Does applicant have speech/language / Learning impairment?: ☐ YES ☐ NO

2. Is applicant verbal? ☐ YES ☐ NO

3. Has applicant had a speech/language/Learning assessment? ☐ YES ☐ NO

4. Assessment done by:

Means of communication:

☐ Speech	☐ Sign Language	☐ Gestures	☐ Communication Board
☐ IPad/Tablets	☐ Other:		

MENTAL HEALTH

1. Does applicant have a history of mental health treatment, alcohol, or substance abuse? ☐ YES ☐ NO

List of previous treatment and dates:

DATE	TREATMENT CENTER	IN-PATIENT or OUT-PATIENT	PSYCHIATRIST/COUNSELOR

2. Is the applicant currently in treatment?

3. Name of Psychiatrist/Counselor: | Phone Number:

4. Diagnosis:

PSYCHOLOGICAL INFORMATION

A. Date of last psychological evaluation:

Performed by:

Address:

Diagnosis:

B. Does applicant have a history of behavioral problems? ☐ YES ☐ NO
(If so, describe the problem using the chart below).

BEHAVIOR	FREQUENCY	SEVERITY	INTERVENTION

C. Has the applicant ever been convicted of a crime? ☐ YES ☐ NO

Provide details:

D. is any other family member diagnosed as having a disability? ☐ YES ☐ NO

Describe:

OTHER PHYSICIANS (Please list any additional physicians for the applicant)

Doctor's Name/Specialty	Address	Phone Number(s)	Date of last appointment

Please indicate if there are any URGENT medical follow-up appointments necessary at the time of admission to the program:

BACKGROUND INFORMATION

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NAME OF SCHOOLS ATTENDED	COMPLETE ADDRESS	DATES ATTENDED
Contact Person:		
ADULT PROGRAMS ATTENDED	**COMPLETE ADDRESS**	**DATES ATTENDED**
Contact Person:		
VOCATIONAL TRAINING OR EVALUATION	**COMPLETE ADDRESS**	**DATES ATTENDED**
Contact Person:		

SKILLS CHECKLIST

A. Is applicant independent in personal self-care skills? ☐ YES ☐ NO

(e.g. bathing, dressing, feeding, toileting)

Type of assistance needed with toileting:

Does (s)he prefer a bath or a shower?

B. Can applicant self-medicate? ☐ YES ☐ NO

C. Can applicant cross streets? ☐ Independently ☐ With Assistance ☐ NO

D. Can applicant use mass transit? ☐ Independently ☐ With Assistance ☐ NO

E. Is applicant capable of remaining at home unsupervised? ☐ YES ☐ NO

If yes, how long?

F. Can applicant read? ☐ YES ☐ NO | If Yes, what level?

G. Does applicant sleep through the night? ☐ YES ☐ NO

H. What time does the applicant usually go to bed?

I. What time does the applicant get up in the morning?

J. What does the applicant like to do in his/her free time?

K. Please provide a brief description of the applicant's daily routine.

L: other Cultural – Religious/Spiritual needs:

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EMERGENCY CONTACTS (OTHER THAN PARENT/GUARDIAN/CAREGIVER)			
Name and Address of local friend/relative (not living at same address):	Relationship to patient:	Home phone number:	Work phone number:
Name and Address of local friend/relative (not living at same address):	Relationship to patient:	Home phone number:	Work phone number:

SIGNATURES	
Signature of Parent/Guardian (If applicable):	Date:
Signature of Applicant (if at least 18 years old):	Date:
Signature of Person completing this form:	Date:

Center for Social Change, Inc.

Center for Social Change provides services and operates its facilities without discrimination on the basis of race, color, national origin, religion, political affiliation, socioeconomic status, marital status, age, gender, sexual orientation or disability. The following information is useful for statistical purposes only; completion of this portion of this application is voluntary.

Religion/Spirituality :					
Ethnic Identification (check as applicable):					
☐ African American	☐ Caucasian	☐ Hispanic	☐ Native American	☐ Asian	☐ Other
U.S. Citizen? ☐ Yes ☐ No			Sex: ☐ Male ☐ Female		
Height:	Weight:		Eye Color:	Hair Color:	
Language(s) spoken or understood: ☐ English ☐ Other, specify:					

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Critical Needs list: ☐ Yes ☐ No

If Yes, check level of services approved:

☐ Vocational Day ☐ Community Housing ☐ ISS ☐ Employment Services

- Crisis Resolution

- Crisis Prevention

-Conflict Resolution

- Current Request

- Waiting List Initiative

- Waiting List Equity

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RELEASE/AUTHORIZATION	
I hereby give permission for the applicant to participate in all program activities, including community trips that require transportation by staff at the Center for Social Change. According to CSC's policies, all transportation will occur in company vehicles. Unless otherwise indicated by a parent/ guardian/caregiver in writing at the time of registration, photographs / audio / videos of program participants may be taken while participating in activities for use in company publications. No personal information other than the participant's first name will be released. In addition, I authorize, Center for Social Change staff to obtain and or release medical/ mental health /educational /hospital / other treatment for the above participant in the event of an emergency or for ongoing care.	
Signature of Parent/Guardian:	Date:
Print Name:	
Signature of Participant (18 or older):	Date:
Print Name:	
Signature of Person completing this form:	Date:
Print Name:	

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