# LIMITLESS POTENTIAL, INC
## APPLICATION FOR SERVICES

**Applicant's Name:** _____ **Sex: M F** **DOB:** ___/___/___

**Your Current Address:** _____ **City:** _____

**State:** _____ **Zip Code:** _____ **Phone:** _____

**Social Security Number:** _____

**Services Requested (**Circle One**):** RB-SCL SCL

**Primary Disability (Degree and Type):** _____
**Other Diagnoses:** _____
**Ambulatory: Yes No**

**Primary language and method of communication:** _____
_____

**County of Financial Responsibility:** _____

**Funding (Check one):**
RB-SCL/Waiver eligible 100% County Funded Private Pay

**Case Manager:** _____ **Phone #:** _____

**Address:** _____
**City:** _____ **State:** _____ **Zip:** _____

**Reason for referral:** _____
_____
_____

**Expectations of services:** _____
_____
_____
_____

**Please explain amount of daily supervision necessary and why:** _____

_____

_____

_____

_____

**Are you ever left alone? Yes No If yes, how long?** _____

**Other community agencies involved:** **Contact Person/Address/Phone**

_____ _____

_____ _____

_____ _____

_____ _____

## FAMILY INFORMATION

Father's Name: _____ Phone:_____

Address: _____

Mother's Name: _____ Phone: _____

Address: _____

Involved Family Members: Address/Phone:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

## FINANCIAL / LEGAL INFORMATION

Do you receive financial assistance? Yes No

If yes, give type of assistance**:** _____ Yearly Amount:_____

Income other than financial assistance (Yearly Amount): _____

Do you have a payee? Yes No

If yes, who? _____

Savings Account: Yes No Checking Account: Yes No

Do you receive Medicaid Insurance? Yes No #: _____

Do you receive Medicare Insurance? Yes No #: _____

Other health insurance? Yes No Company and #: _____

Do you have a funeral trust? Yes No
If yes, with whom and amount of trust? _____

Other Assets / Resources: _____

If applicable, who has legal custody or guardianship? Mother Father Both Parents

If other than parents, please specify: Name: _____

Address: _____ Phone: _____
Date of guardianship: ___/___/___

**PLEASE ATTACH A COPY OF GUARDIANSHIP PAPERS AND FUNERAL TRUST PAPERS WITH THIS APPLICATION.**

Do you have a will? Yes No A Trust? Yes No

Do you have a Power of Attorney? Yes No A Burial Plan? Yes No

**CURRENT MEDICATIONS**

| **Name** | **Dose** | **Frequency** | **Reason for medication** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**MEDICAL INFORMATION**

Current Family Doctor: _____ Date of last exam: ___/___/___

Address: _____ Phone: _____

Current Dentist: _____ Date of last exam: ___/___/___

Address: _____ Phone: _____

Other Specialist: _____ Date of last exam: ___/___/___

Address: _____ Phone: _____

Reason: _____

Other Specialist: _____ Date of last exam: ___/___/___

Address: _____ Phone: _____

Reason: _____

Other Specialist: _____ Date of last exam: ___/___/___

Address: _____ Phone: _____

Reason: _____

Have you been hospitalized in the last 5 years? Yes No

If yes, please explain: _____

_____

_____

_____

Have you ever received any mental health services? Yes No

If yes, please explain: _____

_____

_____

_____

**ALLERGIES**

Are you allergic to:

Medication? Yes No If yes, please explain: _____

Food? Yes No If yes, please explain: _____

Other? Yes No If yes, please explain: _____

**DIET**

Are you on a special diet? Yes No Please explain: _____

_____

_____

**SEIZURES**

Do you have seizures? Yes No

Age of onset: _____ Date of last seizure: ___/___/___

Frequency of seizures: _____

Describe a typical seizure: _____

_____

_____

**ACTIVITY**

List activities / organizations you are involved in: _____

_____

_____

_____

List all activities or limitations you are restricted from as ordered by a medical doctor:

_____

_____

_____

Do you have any physical disabilities that require the use of special devices? (Wheelchair, braces, walker, orthopedic shoes, splints, canes, etc.) Yes No Please explain: _____

_____

_____

**MEDICAL HISTORY**

Are you able to communicate medical needs/concerns? Yes No Please explain: _____

_____

_____

Illnesses Experienced (Check all that apply):

| | | | |
|---|---|---|---|
| Chicken Pox | German Measles | Pneumonia | Measles |
| Polio | Croup | Mumps | Whooping Cough |
| Tuberculosis | Scarlet Fever | Rheumatic Fever | Hepatitis |

Other: _____

**FEARS**

Do you have any fears that would be important for us to know? (heSights, dogs, enclosed spaces, etc.):

_____

_____

_____

**EDUCATIONAL AND/OR WORK/DAY HAB HISTORY** (If applicable)

School/Employer Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School/Employer Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School/Employer Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

## BEHAVIORAL & MENTAL HEALTH

Identified behavioral/mental health issues (Verbal and/or physical aggression, self-injurious behavior, elopement, etc. Include applicable information regarding frequency, severity, and target):

Triggers of the behavioral/psychiatric symptoms:

Cues given that behavior is about to occur (Statements, behaviors, sounds, actions, etc.):

What should staff do in response?

What should staff NOT do in response?

# Skills Checklist

## Please check the items that best describe your abilities

| | Yes | No | Comments: Types of prompts/instructions needed |
|---|---|---|---|
| **EATING / DRINKING** | | | |
| Needs assistance with eating/drinking | | | |
| Able to eat independently | | | |
| Uses adaptive aids/devices | | | |
| **DRESSING** | | | |
| Needs assistance with dressing | | | |
| Able to dress independently | | | |
| **PERSONAL HYGIENE** | | | |
| Needs assistance with hygiene | | | |
| Conducts hygiene independently | | | |
| Uses adaptive aids/devices | | | |
| **TOILETING** | | | |
| Uses incontinent aids | | | |
| Scheduled toileting | | | |
| Can indicate need | | | |
| Assistance transferring on/off the toilet | | | |
| Completely independent in toileting | | | |
| Cares for self during menstrual cycle | | | |
| | | | |
| | | | |

| | Yes | No | Comments: Types of prompts/instructions needed |
|---|---|---|---|
| **MEDICATIONS** | | | |
| Needs assistance when taking medications | | | |
| Takes medications independently | | | |
| Cooperates with taking medications | | | |
| **CHORES AND ACTIVITIES** | | | |
| Does household tasks with assistance | | | |
| Does household tasks independently | | | |
| Does laundry with assistance | | | |
| Does laundry independently | | | |
| Cooks meals with assistance | | | |
| Cooks meals independently | | | |
| Requires supervision in public | | | |
| Makes purchases with assistance | | | |
| Makes purchases independently | | | |
| Uses public transportation (bus, taxi) with assistance | | | |
| Uses public transportation independently | | | |
| Pursues leisure interests independently | | | |
| **SLEEPING HABITS** | | | |
| Sleeps through the night | | | |
| Has a routine for sleep | | | |
| Sleep walks | | | |
| Experiences sleep disorders | | | |
| Wakes up with alarm clock | | | |

| | Yes | No | Comments: Types of prompts/instructions needed |
|---|---|---|---|
| **HUMAN SEXUALITY** | | | |
| Understands the difference between male and female | | | |
| Displays sexually appropriate behavior | | | |
| Sexually active | | | |
| **COMMUNICATIONS** | | | |
| Relates experiences | | | |
| Understands speech | | | |
| Communicates by signing | | | |
| Communicates with augmentative devices | | | |
| Speaks single words/phrases/sentences | | | |
| Speech easily understood | | | |
| Follows simple directions | | | |
| Talks on telephone | | | |
| Knows how to dial a phone | | | |
| Prints/writes | | | |
| Asks for help | | | |
| **SOCIAL RELATIONS** | | | |
| Interacts with peers | | | |
| Interacts with members of the opposite sex | | | |
| Involves self near, but not with others | | | |
| Participates in group activities | | | |
| Maintains friendships | | | |
| Engages in dating | | | |

| | Yes | No | Comments: Types of prompts/instructions needed |
|---|---|---|---|
| Has a significant other | | | |
| Prefers to be alone at times | | | |
| **SAFETY ISSUES** | | | |
| Responds to a smoke alarm | | | |
| Knows how to use Basic First Aid | | | |
| **BEHAVIORAL INFORMATION** | | | |
| Hyperactive | | | |
| Withdrawn | | | |
| Makes disruptive noises | | | |
| Displays self-stimulating behaviors | | | |
| Displays harmful/self-injurious behaviors | | | |
| Mistreatment of property | | | |
| Aggressive/abusive to others | | | |
| Leaves home/work without supervision | | | |
| History of substance abuse | | | |
| Has been arrested | | | |

This application was completed by:

Name: _____

Date: __/__/__

Phone: _____

Relationship to Applicant: _____