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**):** SCL-ID

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

Primary language and method of communication: _____
_____

Current MCO (if applicable): _____

Funding (Check one):
Waiver eligible (MCO) MFP 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**:** _____ Monthly Amount:_____

Income other than financial assistance (Monthly Amount): _____

Do you have a payee? Yes No

If yes, who? _____

Are you willing to allow LPI to be this individual's Representative Payee? Yes No

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: _____