Limitless potential, inc

APPLICATION FOR SERVICES

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**Applicant’s Name:**       **DOB:**      **Male**  **Female**

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

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

**Social Security Number:**

**Services Requested (**Check 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:** 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 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 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.) Please explain:

**MEDICAL HISTORY**

Are you able to communicate medical needs/concerns? Please explain:

Illnesses Experienced:

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? (heights, dogs, enclosed spaces, etc.):      

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

School/Employer: School/Employer: School/Employer:

Name: Name: Name:

Address: Address: Address:

**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: