Limitless potential, inc

APPLICATION FOR SERVICES

Page 1

Page 1

 **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: