

**Developmental Disabilities Ministry
APPLICATION FOR SERVICES**



APPLICANT INFORMATION (please print)

Last Name		First		Middle		Preferred Name		Today's Date	
Street Address				City		State		Zip Code	
Social Security #		Birth Date		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status (Circle One) Single Married Divorced Separated		
Race	Weight	Height	Religious Affiliation		Name of Church			Approximate date services will be needed:	
Type of Service Needed (Check all that apply): <input type="checkbox"/> Respite Care <input type="checkbox"/> In-Home <input type="checkbox"/> Residential Group Home Placement				Location Preference (check all that apply): <input type="checkbox"/> Salem <input type="checkbox"/> Richmond <input type="checkbox"/> Bedford County <input type="checkbox"/> Abingdon <input type="checkbox"/> Fredericksburg <input type="checkbox"/> Virginia Beach <input type="checkbox"/> Martinsville <input type="checkbox"/> Farmville <input type="checkbox"/> No Preference					
Explain Reason Service Is Needed:									
Referral Source (Agency or Individual)				Mailing Address/City/State/Zip				Phone Number ()	
Current Living Arrangements:									

CONTACT INFORMATION FOR APPLICANT

1. Name of Primary Contact		Home Phone ()		Cell/Work Phone () ()		Relationship to Applicant	
Address				City/State/Zip			
Email Address:							
2. Contact (if Primary Contact cannot be located)		Home Phone ()		Cell/Work Phone () ()		Relationship to Applicant	
Address				City/State/Zip			
3. Contact		Home Phone ()		Cell/Work Phone () ()		Relationship to Applicant	
Address				City/State/Zip			

MEDICAL, DENTAL AND PSYCHOLOGICAL INFORMATION

List all current diagnoses:

Primary Care Physician	Address	Phone ()	Date of Last Visit
Dentist	Address	Phone ()	Date of Last Visit
Psychiatrist	Address	Phone ()	Date of Last Visit
Optometrist	Address	Phone ()	Date of Last Visit

Others (Please list specialty, name, address, phone number and date of last visit for each. Use back of page 1 if necessary):

Please list dates of and reason for any hospitalizations/surgeries:

****Please attach copies of any genetic/psychological testing that indicate a diagnosis of mental retardation/ID****

Current Medications (use reverse side if necessary)

Medication	Dosage	Prescribed By	Reason

Type of Diet: Regular Modified Special Explain modified or special diet:

Allergies (including food) or special medical conditions:

Please Check All That Apply:

Physical Impairments	Special Adaptive Devices	Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: <input type="checkbox"/> Petite Mal <input type="checkbox"/> Grand Mal	Date of Last Seizure
<input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Knows sign language <input type="checkbox"/> Non-verbal <input type="checkbox"/> Semi-ambulatory <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Other (Describe):	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Orthopedic or Special Shoes <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Adaptive eating utensils. If yes, please describe. <input type="checkbox"/> Other (Describe):	Frequency: Communication needs: Please list any behavior problems or concerns. Describe fully and list frequency:	

ASSESSMENT OF APPLICANT'S SKILLS (Please Check All That Apply)

Type of Skill	Independently	Requires Assistance	Totally Dependent
Walking			
Dressing self			
Toileting			
Feeding self			
Bathing self			
Washing hair			
Brushing teeth			
Telling time			
Making bed			
Shave (male)			
Menses care (female)			
Understanding Numbers (count, add, subtract)			
Handling money			
Use of leisure time			
Cooking meals			

Significant likes of applicant:

Significant dislikes of applicant:

List recreational activities and hobbies applicant enjoys:

Vocational/Educational Training History

List all vocational or educational training and job experience, if any, that the applicant has received. Attach additional sheets if necessary.

	Training/Experience	Agency/Company (Please include address)	Dates
1.			
2.			
3.			

FINANCIAL

Does applicant have a court-appointed legal guardian? Yes No If yes, date entered If yes, state in which court order was entered

Legal Guardian (Name)	Address
Phone Number ()	City/State/Zip

****Please attach copy of Court Order with Application****

If there is no court appointed legal guardian, does applicant have an authorized representative with another provider?
 Yes No

If yes, Name	Address
Phone Number ()	City/State/Zip

How are the applicant's day-to-day financial needs currently being met?

- Applicant's own resources Other Explain:
 Family resources
 Trust

Have long-term arrangements been made for applicant? Yes No If yes, explain:

Does applicant receive:	Amount
<input type="checkbox"/> SSI (Supplementary Security Income)	\$ _____
<input type="checkbox"/> SSDI (Supplemental Security Disability Income)	_____
<input type="checkbox"/> Social Security	_____
<input type="checkbox"/> Other _____	_____

If applicant receives Social Security benefits, from whose Social Security benefits does he/she draw?

- His/Her own benefits Parent's benefits

If receiving benefits from parent, please give Parent's Name

Parent's SS #

Name of person responsible for medical:

- Is this person: Parent/Guardian
 Representative
 Other

Is applicant eligible to receive:

Medicaid Yes No Medicaid #:

Medicare Yes No

Medicare #:

(1) Is applicant covered by a personal health insurance, either individually or with coverage provided under guardian's insurance?
 Yes No

Policy ID #

Group #

Name/Address of Insurance Company

Name of person taking out policy on applicant

(2) Does applicant have any other insurance benefits (ex. Life, Champus, Railroad Retirement, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name/Address of Insurance Company	Name of person taking out policy on applicant
Policy ID#	Group #		

Does applicant have a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does applicant have an Advanced Medical Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Does applicant have a "DO NOT RESUSCITATE" order? Yes No

Please provide any burial plans made for applicant:

CURRENT AND PREVIOUS SERVICES RECEIVED

Please list and provide addresses, telephone numbers, Case Managers/Support Coordinator and dates of services, as applicable. Attach additional sheets if necessary.

Community Services Board System:

MR/ID Services:

Mental Health Services:

Social Services:

Department of Rehabilitative Services:

Private Placement Services:

Criminal Justice Status – Has applicant ever been charged with or been convicted of any violation of the law?
 Yes No If yes, please provide details:

 Person Completing Application Date

Relationship to Applicant _____

**Send completed application to: VBCH&FS/DDM
 PO Box 849
 Salem VA 24153**