

# Caroline Center, Inc.

## APPLICATION FOR RESIDENTIAL SERVICES

### Select Program(s) for which application is being submitted

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Supported Living</b><br><input type="checkbox"/> <i>Enhanced</i> | <input type="checkbox"/> <b>Community Living – Group Home</b><br><input type="checkbox"/> <i>Enhanced</i> |
| <input type="checkbox"/> <b>Transition Services</b>  | <input type="checkbox"/> <b>Shared Living</b>   |

### Select all ADDITIONAL Program(s) for which application is being submitted

- |  |   |
|--|---|
| <input type="checkbox"/> <i>Employment Services</i>            | <input type="checkbox"/> <i>Follow-along Supports</i>       |
| <input type="checkbox"/> <i>Discovery</i>                      | <input type="checkbox"/> <i>Self-Employment Development</i> |
| <input type="checkbox"/> <i>Community Living</i>               | <input type="checkbox"/> <i>Job Development</i>             |
| <input type="checkbox"/> <i>Day Habilitation</i>               | <input type="checkbox"/> <i>On-going Supports</i>           |
| <input type="checkbox"/> <i>Community Development Services</i> | <input type="checkbox"/> <i>Other</i>                       |

## PERSONAL INFORMATION

|   |  |                                       |                     |
|---|--|---------------------------------------|---------------------|
| <b>Applicant's Name</b>                           | _____                                  | _____                                 | _____               |
|   | <i>Last Name</i>                       | <i>First Name</i>                     | <i>Middle</i>       |
| <b>Current Address</b>                            | _____                                  | _____                                 | _____               |
|   | <i>Street</i>                          | <i>City</i>                           | <i>Street</i>       |
|   | _____                                  |                                       | <i>Zip Code</i>     |
|   | <i>Number of years at this address</i> |                                       |                     |
| <b>Permanent Address</b><br><i>(if different)</i> | _____                                  | _____                                 | _____               |
|   | <i>Street</i>                          | <i>City</i>                           | <i>State</i>        |
|   | _____                                  |                                       | <i>Zip code</i>     |
|   | <i>Number of years at this address</i> |                                       |                     |
| <b>Primary Phone #</b>                            | _____                                  | <b>Email Address</b>                  | _____               |
| <b>Date of Birth</b>                              | _____                                  | <b>Place of Birth</b>                 | _____               |
|   | <i>Month, Day &amp; Year</i>           |                                       | <i>City / State</i> |
| <b>Gender</b>                                     | _____                                  | <b>Height</b>                         | _____               |
|   |  | <b>Weight</b>                         | _____               |
| <b>Eye Color</b>                                  | _____                                  | <b>Hair Color</b>                     | _____               |
| <b>Preferred Language</b>                         | _____                                  | <b>Preferred Communication Method</b> | _____               |
| <b>Applicant's Martial Status</b>                 | _____                                  | <b>Applicant's Social Security #</b>  | _____               |

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## EMERGENCY CONTACT

Parent/Guardian Name \_\_\_\_\_  
*Last* *First* *Middle*

Parent/Guardian Address \_\_\_\_\_  
*Street* *City* *State*  
\_\_\_\_\_  
*Zip Code*

Relationship to Applicant \_\_\_\_\_ Primary Phone # \_\_\_\_\_

Alternate Phone # \_\_\_\_\_

Does applicant have a legal guardian?  Yes  No



Name \_\_\_\_\_

Primary Phone # \_\_\_\_\_

Alternate Phone # \_\_\_\_\_

| Type of Guardianship     |          |                          |         |
|--------------------------|----------|--------------------------|---------|
| <input type="checkbox"/> | Full     | <input type="checkbox"/> | Limited |
| <input type="checkbox"/> | Property | <input type="checkbox"/> | Medical |

## FAMILY OR PRIMARY CAREGIVER INFORMATION

(If different from Emergency Contact)

Father's Name \_\_\_\_\_  
*Last* *First* *Middle*

Address \_\_\_\_\_  
*Street* *City* *State*  
\_\_\_\_\_  
*Zip Code*

Primary Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Mother's Name \_\_\_\_\_  
*Last* *First* *Middle*

Address \_\_\_\_\_  
*Street* *City* *State*  
\_\_\_\_\_  
*Zip Code*

Primary Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

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## WAIVER & FINANCIAL INFORMATION

*Please select from the following*

Community Pathways

Community Supports

Applicant's Social Security # \_\_\_\_\_

Applicant's Medicaid (Medical Assistance Number) \_\_\_\_\_

Applicant's Medicare Number \_\_\_\_\_ Part A  Part B

Other Medical Insurance \_\_\_\_\_  
(ID #)

SSI Amount \_\_\_\_\_ /mo.

SSA Amount \_\_\_\_\_ /mo.

SSDI Amount \_\_\_\_\_ /mo.

Other Benefits \_\_\_\_\_ Other Sources of Applicant's Income \_\_\_\_\_

Any property in Applicant's Name  Yes  No



Location & Estimated Value \_\_\_\_\_ \$ \_\_\_\_\_  
Location Estimated Value

Does Applicant have a Trust Fund  Yes  No



Name & Address of Trustee \_\_\_\_\_  
Name Address of Trustee

Name of Representative Payee, if different from Applicant \_\_\_\_\_

# Caroline Center, Inc.

## EDUCATIONAL INFORMATION

| <i>Name of School(s) Attended</i> | <i>Date(s) Attended</i> |
|-----------------------------------|-------------------------|
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |

| <i>Adult Program(s) Attended</i> | <i>Date(s) Attended</i> |
|----------------------------------|-------------------------|
|                                  |                         |
|                                  |                         |
|                                  |                         |
|                                  |                         |
|                                  |                         |

## MEDICAL INFORMATION

Applicant's Primary Health Care Provider / Physician \_\_\_\_\_  
Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
Date of Applicant's Last Physical Exam \_\_\_\_\_  
Hospital Preference \_\_\_\_\_

### DIAGNOSIS

PRIMARY \_\_\_\_\_  
SECONDARY \_\_\_\_\_  
TERTIARY \_\_\_\_\_  
AGE OF ONSET \_\_\_\_\_

### MEDICATIONS

| <i>MEDICATION</i> | <i>DOSAGE</i> | <i>REASON</i> |
|-------------------|---------------|---------------|
|                   |               |               |
|                   |               |               |
|                   |               |               |
|                   |               |               |
|                   |               |               |
|                   |               |               |

# Caroline Center, Inc.

List any drug or environmental allergies (i.e., medications, bee stings, drugs, dust, mold, food, etc.) \_\_\_\_\_

## DENTAL

Date of last dental examination \_\_\_\_\_

Does Applicant wear dentures?  Yes  No

Brief description of any dental problem(s) \_\_\_\_\_

## DIETARY

Dietary needs (i.e.; thickened liquids, chopped, ground) \_\_\_\_\_

## SPEECH & LANGUAGE

Does Applicant have any speech / language impairment?  Yes  No

Is Applicant Verbal?  Yes  No

Has Applicant had a Speech / Language Assessment?  Yes  No



Assessment completed by: \_\_\_\_\_

- Means of communication
- Speech
  - Sign Language
  - Gestures
  - Communications Board
  - Other

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## SUBSTANCE & PSYCHOLOGICAL INFORMATION

**Does Applicant have a history of substance abuse?**

Yes    No

↓

*If yes, please list:* \_\_\_\_\_

\_\_\_\_\_

*List previous treatment and dates* \_\_\_\_\_

\_\_\_\_\_

**Has the Applicant ever been convicted of a crime?**

Yes    No

↓

*If yes, provide details:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date of last Psychological Evaluation** \_\_\_\_\_

*Performed by:* \_\_\_\_\_

**Address** \_\_\_\_\_

**Diagnosis** \_\_\_\_\_

**Does applicant have a formal written Behavior Plan that addresses behavioral issues?**

Yes    No

*(If yes, please attach a copy of the Behavioral Plan to this application)*

**Has applicant received any Behavioral Health Services in the past 3 years?**

Yes    No

*(i.e.; counseling outpatient or inpatient psychiatric services)*

*If yes, please describe* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Additional Comments* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## ADDITIONAL INFORMATION

**MUST INCLUDE COPIES OF THE FOLLOWING:**

*HRST, Current Outcomes (PCP) and Behavior Plan (If applicable)*

Any other information of which we should be aware? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent/Guardian**  
*(If applicable)*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Participant**  
*(If at least 18 yoa)*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Person Completing Form**

\_\_\_\_\_  
**Date**

*Agency provides services and operates its facilities without discrimination on the basis of race, color, national origin, religion, political affiliation, marital status, age, sex, or physical or mental limitations.*