Caroline Center, Inc.

APPLICATION FOR SUPPORT SERVICES

Select program(s) for which application is being submitted

- ☐ *Participation Education, Training & Advocacy*
- ☐ *Personal Supports*
- ☐ *Remote Supports*
- ☐ *Respite*
- ☐ *Assistive Technology*
- ☐ *Transition services*
- ☐ *Family & Peer Mentoring*
- ☐ *Live-in Caregiver*
- ☐ *Environmental Modification*
- ☐ *Environmental Assessment*
- ☐ *Transportation*
- ☐ *Vehicle Modification*

PERSONAL INFORMATION

Applicant's Name _____ *Last* _____ *First* _____ *Middle* _____ *Nickname*

Current Address _____ *Street* _____ *City* _____ *State*

_____ *Zip Code* _____ *# of years resided at this address*

Permanent Address *(if different)* _____ *Street* _____ *City* _____ *State*

_____ *Zip Code* _____ *# of years resided at this address*

Date of Birth _____ *Month, Day & Year* **Place of Birth** _____ *City / State*

Primary Phone # _____ **Email address** _____

Gender _____ **Height** _____ **Weight** _____

Eye Color _____ **Hair Color** _____

Preferred Language _____ **Preferred Communication Method** _____

Applicant's Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐

Dev. 5.6.21
Rev. 8.25.21

Caroline Center, Inc.

PARENT/GUARDIAN/CAREGIVER INFORMATION

(if applicable)

Parent/Guardian Name _____ (*Last*) _____ (*First*) _____ (*Middle*)

Parent/Guardian Address _____ (*Street*) _____ (*City*) _____ (*State*)

_____ (*Zip Code*)

Relationship to Applicant _____ **Primary Phone #** _____

Alternate Phone # _____

EMERGENCY CONTACT

Name _____ (*Last*) _____ (*First*) _____ (*Middle*)

Address _____ (*Street*) _____ (*City*) _____ (*State*)

_____ (*Zip Code*)

Relationship to Applicant _____ **Primary Phone #** _____

Alternate Phone # _____

BEST CONTACT PERSON FOR THIS APPLICANT

☐ **SELF;**

↓

OR *(Fill in information below)*

Name _____ (*Last*) _____ (*First*) _____ (*Middle*)

Address _____ (*Street*) _____ (*City*) _____ (*State*)

_____ (*Zip code*)

Primary Phone # _____ **Alternate Phone #** _____

Email Address _____

Dev. 5.6.21
Rev. 8.25.21

Caroline Center, Inc.

WAIVER & FINANCIAL INFORMATION

Please select from the following

☐ *Waiver Enrollment Community Supports* ☐ *Community Pathways* ☐ *Application Pending*

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** _____

Name of Representative Payee, if different from Applicant _____

EDUCATIONAL INFORMATION

Name of School(s) Attended	*Date(s) Attended*

Adult Program(s) Attended	*Date(s) Attended*

Dev. 5.6.21
Rev. 8.25.21

Caroline Center, Inc.

MEDICAL INFORMATION

DISABILITY

Please check appropriate spaces that best describe the applicants' disability / disabilities

DISABILITY	COMMENTS
☐ *Learning Disability*	_____
☐ *Mild Intellectual Disability*	_____
☐ *Moderate Intellectual Disability*	_____
☐ *Severe Intellectual Disability*	_____
☐ *Profound Intellectual Disability*	_____
☐ *Chronic Mental Illness*	_____
☐ *Emotional Disturbance*	_____

Please check appropriate spaces that best describe the applicant's disability / disabilities

☐ **VISION**

Does applicant wear glasses or contact lenses? ☐ *Yes* ☐ *No*

Date of last examination _____

Comment(s) _____

Legally blind? ☐ *Yes* ☐ *No*

☐ **HEARING IMPAIRMENT**

Does applicant wear a hearing aid? ☐ *Yes* ☐ *No*

Date of last hearing evaluation _____

Comment(s) _____

Is the applicant deaf? ☐ *Yes* ☐ *No*

☐ **EPILEPSY / SEIZURE DISORDER**

Frequency *(select one)*

- ☐ Daily
- ☐ At least once a month
- ☐ Weekly
- ☐ Every few months
- ☐ Other _____

Are seizures controlled by medication? ☐ *Yes* ☐ *No*

☐ **CEREBRAL PALSY**

☐ **AUTISM**

☐ **MOBILITY IMPAIRMENT**

☐ *Uses cane* ☐ *Uses crutches*

☐ *Uses walker* ☐ *Uses wheelchair* ☐ *Manual* ☐ *Electric*

☐ **OTHER** _____

Dev. 5.6.21
Rev. 8.25.21

Caroline Center, Inc.

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 TAKEN BY APPLICANT

MEDICATION	*DOSAGE*	*REASON*

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 _____

Dev. 5.6.21
Rev. 8.25.21

Caroline Center, Inc.

ADDITIONAL INFORMATION

MUST INCLUDE COPIES OF THE FOLLOWING:
Current Outcomes (PCP), HRST, and Behavior Plan Iff 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.

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