Caroline Center, Inc.

APPLICATION FOR MEANINGFUL DAY SERVICES

Select program(s) for which application is being submitted

- ☐ *Day Habilitation*
- ☐ *Community Development Services*
- ☐ *Employment Services*
- ☐ *Discovery*
- ☐ *Job Development*
- ☐ *On-going Supports*
- ☐ *Follow-along Supports*
- ☐ *Self-Employment Development*

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

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

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** _____

Dev. 5.6.21
Rev. 10.7.21

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

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

Parent/Guardian 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. 10.7.21

Caroline Center, Inc.

WAIVER & FINANCIAL INFORMATION

Please select from the following
☐ *Community Pathways* ☐ *Waiver Enrollment Community Supports* ☐ *Application Pending*

Applicant's Social Security # _____

Applicant's Medicaid / Medical Assistance Number _____

Applicant's Medicare Number _____ Part A ☐ Part B ☐

Other Medical Insurance _____
(ID #)

SSI Amount _____

SSA Amount _____

SSDI Amount _____

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. 10.7.21

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 applicants' 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 late hearing evaluation _____

Comment(s) _____

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. 10.7.21

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

MEDICATION	*DOSAGE*	*REASON*

Does applicant have a formal written Behavior Plan that addresses behavioral issues? ☐ *Yes* ☐ *No*

(If yes, please indicate the name of the writer, and attach a copy of the Behavioral Plan to this application.) _____ *(Name of the writer)*

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. 10.7.21

Caroline Center, Inc.

ADDITIONAL INFORMATION

MUST INCLUDE COPIES OF THE FOLLOWING:
HRST, Current Outcomes (PCP), and if applicable BP and/or CIE

Any other information of which we should be aware? _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian **Date**
(If applicable)

_____ _____

Signature of Participant **Date**
(If at least 18 yoa)

_____ _____

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.

Dev. 5.6.21
Rev. 10.7.21