RICHCROFT
See the ability.

Application for Services

(Please Print or Type)

Date of Application: ___________________

Check program(s) for which application is being submitted. Please print clearly when completing the application.

ADULT SERVICES

❑ Residential Services ❑ Respite Care ❑ Personal Supports ❑ CDS Day Service

APPLICANT'S GENERAL INFORMATION

Name: ____
Last First Middle

Date of Birth:____/____/_____ Place of Birth:____

Current Address: ____
Street City State Zip # of years

Permanent Address: ____
Street City State Zip # of years

County: ___________________ County of Interest: _____________________

Telephone #:____

Social Security #: ______________________________ Type of Income/Amount:______________________

Medical Assistance #:________________________________ Medicare #:__________________________

Other Health Insurance:______________________________ Prescription Coverage:________________

Does Applicant have a Service Coordinator? ____
Name Phone #

PARENT/GUARDIAN/CAREGIVER INFORMATION

Name: ____ Relationship to Applicant: ____________________

Address: ____

City/State/Zip: ____

Phone Number: _________________________________ Cell Phone Number:__________________________

E-Mail Address:____

May we send you information via e-mail? ____

APPLICANT'S LIVING SITUATION – **Please include names**

Parents: ________________________________ Guardian or Relatives: ______________________

Foster Home: ____________________________ Other: ___________________________________

Address: ____

Phone Number: ___________________________ Legal Guardian: ❑ YES ❑ NO

Date Guardianship was attained: _____________ Number of occupants living in the home: _________

Type of Guardianship (Check whichever applies):

❑ Full ❑ Property ❑ Limited ❑ Medical ❑ Person

FAMILY INFORMATION

FATHER		MOTHER	
Name:		Name:	
Birth Date:		Birth Date:	
Address:		Address:	
Home Phone:		Home Phone:	
Occupation:		Occupation:	
Work Phone:		Work Phone:	
Work Address:		Work Address:	
Social Security #:		Social Security #:	
Living/Deceased If deceased, date:		Living/Deceased If deceased, date:	
Place of Birth:		Place of Birth:	
Marital Status:		Marital Status:	

BROTHERS AND SISTERS (Use additional paper if necessary):

NAME	BIRTH DATE	PHONE #	ADDRESS	OCCUPATION

OTHER FAMILY MEMBERS LIVING IN THE HOME (Use additional paper if necessary):

NAME	BIRTH DATE	RELATION TO APPLICANT	PHONE #	OCCUPATION

EMERGENCY CONTACT: (Other than Parent/Guardian/Caregiver)

Name: ____________________________________ Relationship to applicant:_________________

Address:___________________________________ Phone Number:_________________________

APPLICANT'S FINANCIAL INFORMATION **(If applying for Respite, do not complete this section)**

SSI Claim #:_________________________________ SSI Amount:______________________________

SSA Claim #:________________________________ SSA Amount:______________________________

Does Individual have an overpayment with Social Security? ❑ YES ❑ NO If yes, why? (Please include letter from Social Security with explanation) ____

Name of wage earner:____

Is the parent a Veteran? ❑ YES ❑ NO If yes, who? ________________

Is either parent retired? ❑ YES ❑ NO If yes, who? ________________

Is either parent deceased? ❑ YES ❑ NO If yes, who? ________________

Name of Representative Payee:____

V.A. Claim #:_________________________________V.A. Benefit Amount:__________________________

Name of Veteran:____

Railroad Retirement Claim Number:____

Name of Wage earner:__________________________ Life Insurance Coverage:____________________

Burial Plot location:____

Estimated value:______________________________ Type of Burial Plan:_________________________

Other sources of Applicant's Income:____

List all Bank Accounts that are held either solely by the applicant or jointly with another party. Attach copy of most recent statement(s).

Bank Name(s) and type of account:

____

____

____

Any property in applicant's name (give location and value):_____________________________________

Trust Fund: ❑ YES ❑ NO Type: ____

If yes, give name and address of trustee:____

Applicant's place of employment (name and address):____

Applicant's monthly earnings from employment:____
Attach copy of two most recent paystub.

MEDICAL INFORMATION

A. Applicant's primary health care provider/physician:_______________________________________

Address:____

Phone Number:_________________________________ Date of last physical exam:_____________

Examined by:______________________________ Address:___________________________________

Hospital familiar with applicant (if any):____

B. Diagnosis

Primary:____

Secondary:____

Tertiary:____

Age of Onset:____

C. Does applicant have a formal behavioral plan that agency developed? ❑ YES ❑ NO

Name of agency that developed the plan. ____

D. List any medication(s) taken by applicant

MEDICATION	DOSAGE	REASON

E. History of Hospitalizations

DATE	REASON	HOSPITAL	PHYSICIAN

F. Seizures

1. Does the applicant have seizures? ❑ YES ❑ NO
2. Frequency: ❑ Daily ❑ Weekly ❑ At least once a month ❑ Every few months

3. Type of seizures:____
4. Are seizures controlled by medication? ❑ YES ❑ NO

G. Applicant's Mobility

❑ Walks independently ❑ Uses cane ❑ Uses crutches ❑ Uses walker

❑ Uses wheelchair ❑ YES ❑ NO ❑ Manual ❑ Electric ❑ Self propelled

H. Vision

1. Any vision impairment: ❑ YES ❑ NO
2. Does applicant wear glasses or contact lenses? ______________________________
3. Date of last eye exam:____________________ Legally Blind: ❑ YES ❑ NO

I. Hearing

1. Does applicant have a hearing problem? ❑ YES ❑ NO
2. Does applicant wear a hearing aid: ❑ YES ❑ NO
3. Date of last hearing exam:________________ Deaf: ❑ YES ❑ NO

J. Dental

1. Date of last dental exam:______________________________ Dentures: ❑ YES ❑ NO
2. Brief description of any dental problem(s):____
3. Is individual currently in need of any dental procedures? ❑ YES ❑ NO
   Please include statement from dentist indicating general dental health.

K. Equipment Needed

❑ Hoyer Lift ❑ Bed Rails ❑ Need for oxygen? ❑ Other adaptive / special equipment__________
____

L. Allergies (bee stings, drugs, dust, mold, food, etc.)

____

____

Does applicant have any other medical problems not listed?
____

____

Diet (chopped food, tube fed, finger foods etc.)_______________________________________
____

SPEECH AND LANGUAGE INFORMATION

1. Does applicant have a speech/language impairment: ❑ YES ❑ NO
2. Is applicant verbal? ❑ YES ❑ NO
3. Has applicant had a speech/language assessment? ❑ YES ❑ NO
4. Assessment done by:____
5. Means of communication:

   ❑ Speech ❑ Sign Language ❑ Gestures ❑ Communication Board

MENTAL HEALTH

1. Does applicant have a history of mental health treatment, alcohol or substance abuse? ❑ YES ❑ NO

   List previous treatment and dates:

DATE	TREATMENT CENTER	IN-PATIENT OR OUT-PATENT	PHYSICIAN/COUNSELOR

2. Is the applicant currently in treatment? ❑ YES ❑ NO
3. Name of psychiatrist/counselor:____________________
4. Diagnosis:____________________

PSYCHOLOGICAL INFORMATION

A. Date of last psychological evaluation:____________________

Performed by: ____________________

Address:____________________

Diagnosis:____________________

B. **Does applicant have a history of behavioral problems?** ❑ YES ❑ NO
(If so, describe the problem using the chart below).

BEHAVIOR	FREQUENCY	SEVERITY	INTERVENTION

C. **Has the applicant ever been convicted of a crime?** ❑ YES ❑ NO

Provide details:____________________

D. **Is any other family member diagnosed as having a disability?** ❑ YES ❑ NO
Describe:____________________

BACKGROUND INFORMATION

NAME OF SCHOOLS ATTENDED	COMPLETE ADDRESS	DATE

Contact person:____________________

ADULT PROGRAMS ATTENDED	COMPLETE ADDRESS	DATE

Contact person:____

VOCATIONAL TRAININGS OR EVALUATION	COMPLETE ADDRESS	DATE

Contact person:____

SKILLS CHECKLIST

A. Is applicant independent in personal self-care skills? ❑ YES ❑ NO
(e.g. bathing, dressing, feeding, toileting)

Type of assistance needed with toileting: ______________________________

Does (s)he prefer a bath or a shower?______________________________

B. Can applicant self medicate? ❑ YES ❑ NO

C. Can applicant cross streets? ❑ Independently ❑ With Assistance ❑ No

D. Can applicant use mass transit? ❑ Independently ❑ With Assistance ❑ No

E. Is applicant capable of remaining at home unsupervised? ❑ YES ❑ NO

If yes, how long? ____

F. Can applicant read? ❑ No ❑ Yes What level? ________________________

G. Does applicant sleep through the night? ❑ YES ❑ NO

H. What time does the applicant usually go to bed? ____________________________

I. What time does the applicant get up in the morning? __________________________

J. What does the applicant like to do in his/her free time? ________________________

____

____

____

K. Please provide a brief description of the applicant’s daily routine.________________________

____

____

Has applicant received or is receiving any type of services or financial assistance from Richcroft, Inc. or any other agency? (i.e. Rolling Access, Respite Services, In-Home Support, Foster Care etc.) ❑ YES ❑ NO

If yes, please list agency / agencies and explain in detail____________________________

____

____

SIGNATURES

____ ____________________
Signature of parent/guardian (if applicable) Date

____ ____________________
Signature of parent/guardian (if at least 18 years old) Date

____ ____________________
Signature of person completing this form Date

Richcroft, Inc. provides services and operates its facilities without discrimination on the basis of race, color, national origin, religion, political affiliation, marital status, age, sex or disability. The following information is useful for statistical purposes only; completion of this portion of this application is voluntary.

Religion: ____

Ethnic Identification (check as applicable):

❑ Black ❑ Caucasian ❑ Hispanic ❑ Native American ❑ Asian

❑ Other ___________________________

U.S. Citizen? ❑ Yes ❑ No Sex: ❑ Male ❑ Female

Height: ________ Weight: ___________ Eye Color: __________ Hair Color: ___________

Language(s) spoken or understood: ❑ English ❑ Other, specify: _______________________

Language(s) used in Applicant's home environment: ❑ English ❑ Other, specify: _____________

AUTHORIZATION TO OBTAIN INFORMATION

Date authorization becomes effective: __________________ and expires on _________________.

I, ____ hereby authorize

_________________________________ __________________________________ ________________

Clinician/Doctor/Evaluator Name Address Phone Number

to release the following : _____ Social History _____ Psychological Reports _____Vocational Evaluations
_____Medical Information _____Counseling Reports _____Other (specify)___________________________

to Richcroft Inc., 11350 McCormick Road, Suite 700, Executive Plaza 4, 7th Floor, Hunt Valley, MD 21031.

I understand that the information being requested will be used by Richcroft, Inc. to assist in determining the agency's capacity to support me now and/or assist in planning with me for the future.

I understand that all information shared with Richcroft, Inc. will be treated in a strictly confidential manner, and any further sharing of my information will require my additional authorization. I understand that authorization is extended for this request only and at this time only.

I understand that I have the right to revoke this authorization in writing at any time except to the extent that action on this authorization has already occurred (i.e. the information was already distributed).

____ ______________________

Individual's Signature Date

____ ______________________

Parent/Guardian (must sign if person is under 18) Date

____ ______________________

Witness (must sign if "X" is used) Date

____

Relationship of Witness to Individual

____ ______________________

Agency Representative Date

____

Title of Agency Representative

Updated 3/2021