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

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. List any medication(s) taken by applicant

MEDICATION	DOSAGE	REASON

D. History of Hospitalizations

DATE	REASON	HOSPITAL	PHYSICIAN

E. 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

F. Applicant's Mobility

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

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

G. 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

H. 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

I. 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.

J. Equipment Needed

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

_____

K. 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 Rd., Suite 700, Executive Plaza IV, 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