The Arc Baltimore

Achieve with us.

The Arc Baltimore
Application for Services
(Please Print or Type)

Date of Application: _____

Check program(s) for which application is being submitted.

ADULT SERVICES
- ❑ Community Employment ❑ Day/Vocational
- ❑ Respite Care ❑ Community Living
- ❑ Information Referral & Advocacy
- ❑ Individual Support Services

CHILDREN SERVICES
- ❑ Respite Care
- ❑ In-Home Supports for Children
- ❑ Information Referral and Advocacy

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

Telephone #:_____

Baltimore City/County of Residence:_____

Social Security #: _____

Type of Income/Amount:_____

Medicare #:_____

Medical Assistance #:_____

Other Health Insurance:_____

Prescription Coverage:_____

Does Applicant have a Service Coordinator? _____

_____

Name Phone #

PARENT/GUARDIAN/CAREGIVER INFORMATION

Name: _____

Address:_____

City/State: _____

Phone: _____

Relationship to Applicant: _____

APPLICANT'S LIVING SITUATION/FAMILY SITUATION – Please include names

Parents: _____

Guardian or Relatives: _____

Foster Home: _____

Other: _____

Address: _____

Phone Number: _____

Legal Guardian: _____

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

SSI Claim #:_____ SSI Amount:_____

SSA Claim #:_____ SSA Amount:_____

Name of wage earner:_____

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:_____

Applicant's Bank Account:_____

Bank Name:_____

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:
_____

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

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 ❑ Manual ❑ Electric

G. Vision

1. Any vision impairment: ❑ YES ❑ NO
2. Does applicant wear glasses or contact lenses? _____
3. Date of last eye exam:_____
4. 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):
   _____

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

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

_____

_____

Does applicant have any other medical problems not listed?

_____

_____

_____

_____

MENTAL HEALTH

1. Does applicant have a history of mental health, 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)

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?

❑ No ❑ 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?

_____

_____

_____

_____

_____

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

The Arc Baltimore 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: _____

FOR OFFICE USE ONLY

Critical Needs list: ❑ Yes ❑ No
If yes, check level of services approved:
❑ Day ❑ Residential ❑ ISS ❑ Vocational

-Crisis Resolution
_____

-Crisis Prevention
_____

-Current Request
_____

-Waiting List Initiative
_____

-Waiting List Equity

This application form has been developed jointly by the Baltimore Commission on Disabilities and the Developmental Disabilities Directorate of Baltimore for the purpose of simplifying the process by which an individual applies for services in Baltimore City and Baltimore County.

The Arc Baltimore

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Achieve with us.

Date: _____

Name of person with developmental disability: _____

D.O.B._____

Address:
_____

_____

I, _____, hereby authorize _____
Doctor's Name,
Clinic/Hospital Name
or other pertinent
professional/agency

_____
Address with Zip Code

_____
Phone Number

to release medical, psychological, social narrative and other pertinent information to The Arc Baltimore as presently requested by same. Authorization is extended for this request only and at this time only.

I understand that the information is requested for the purpose of assisting The Arc Baltimore in serving me now and/or planning with me for the future.

I understand that all information will be treated in a strictly confidential manner.

Signature	Date
Parent/Guardian (must sign if client is under 18)	Date
Witness (must sign if “X” is used)	Date
Agency Representative	Date