

REQUEST FOR SERVICES

Reason for Referral: Transition to Adult Services
 Other: _____

Applicant Name: _____
 (First) (Middle) (Maiden) (Last)

Date of Birth: _____ Sex: Female Male

Current Address: _____
 (Street) (City) (State) (Zip)

Permanent Address: _____
 (Street) (City) (State) (Zip)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____

Family Contact: _____
 (First) (Middle) (Last) (Type of Relationship)

Address: _____
 (Street) (City) (State) (Zip) (Email address)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Additional Contact: _____
 (First) (Middle) (Last) (Type of Relationship)

Address: _____
 (Street) (City) (State) (Zip) (Email address)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

SCHOOL INFORMATION – Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Currently attending school | Date school services projected to end: _____ |
| <input type="checkbox"/> Graduated with signed diploma | Date school services ended: _____ |
| <input type="checkbox"/> Received certificate of completion | Date school services ended: _____ |

School: _____ **Contact Person:** _____ **Phone:** _____

LEGAL REPRESENTATIVE/CONSERVATORSHIP – Check all that apply to the applicant if over 18 years old.

- Court Ordered Legal Representative and type (medical, limited, etc.): _____
- Court Ordered Conservator and Name if different from Legal Representative: _____
- Power of Attorney and type: _____
- No Legal Representative in place.

Legal Representative's Name: _____
 (First) (Middle) (Last)

Address: _____
 (Street) (City) (State) (Zip) (Email address)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

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SERVICES REQUESTED – Check all that apply

<input type="checkbox"/> Educational Services <input type="checkbox"/> Integrated Classroom	<input type="checkbox"/> Self-Contained Classroom	Requested Start Date: _____
<input type="checkbox"/> Employment Services <input type="checkbox"/> Day Services	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Community Employment Requested Start Date: _____
<input type="checkbox"/> Residential Services (i.e., independent living skills, community living skills, financial, personal living, etc.)	Requested Start Date: _____	
<input type="checkbox"/> Live with family <input type="checkbox"/> Live alone <input type="checkbox"/> Live with roommate	<input type="checkbox"/> Group Home <input type="checkbox"/> Supervised apartment <input type="checkbox"/> Rent apartment or home <input type="checkbox"/> Buy house	<input type="checkbox"/> 24 hr. support needed <input type="checkbox"/> Daily support needed <input type="checkbox"/> Weekly support needed <input type="checkbox"/> Other: _____

DEVELOPMENTAL DISABILITY DIAGNOSIS – Check all that apply

(If available attach Psychological Evaluation) Please refer to evaluations for formal diagnosis:

IQ: <input type="checkbox"/> Mild (52-70) <input type="checkbox"/> Moderate (36-51) <input type="checkbox"/> Severe (20-35) <input type="checkbox"/> Profound (20 or below) <input type="checkbox"/> Borderline (71-85)	<input type="checkbox"/> Down Syndrome <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Epilepsy/Seizure Disorder <input type="checkbox"/> Autism <input type="checkbox"/> Aspergers Disorder	<input type="checkbox"/> Fetal Alcohol spectrum Disorder <input type="checkbox"/> Traumatic Brain Injury (prior to age 22) <input type="checkbox"/> Cognitive Disability <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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FINANCIAL INFORMATION – Check all that apply

To assist in determining applicant's eligibility for services, please list sources and amounts of income:

<input type="checkbox"/> Medicare Number _____	<input type="checkbox"/> Medicaid Number _____
<input type="checkbox"/> Social Security Number _____	Amount _____ Payee: _____
<input type="checkbox"/> Supplemental Security Income	Amount _____ Payee: _____
<input type="checkbox"/> Social Security Disability Insurance	Amount _____ Payee: _____
<input type="checkbox"/> Veteran's Administration	Amount _____ Payee: _____

Other sources of Income and Amount: (e.g.: joint bank accounts, Indian Land Lease, trusts, stocks, bonds, CDs, wages, interest, property owned, etc.) _____

SUPPORT NEEDS – Check all that apply. (if applicable, attach extra page(s).

cannot walk alone cannot do steps
 Intentionally hurts self
 Please describe: _____
 What appears to cause this? _____
 What is frequency? _____

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Required documents to enclose with this application – Check and attach all that apply

IEP (if applicable)
(Multidisciplinary Team Assessment)

Diagnosis Documentation
(Psychological Evaluation and Medical Information)

Court Order for Legal Representation

Criminal Convictions No Yes

If yes, please describe: _____

I acknowledge this is a request for agency planning purposes. Completion of this form is not a guarantee of services nor is it a commitment on my part to accept offered services.

APPLICANT SIGNATURE: _____

PARENT/LEGAL REPRESENTATIVE SIGNATURE: _____

DATE: _____