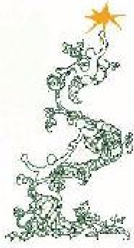

ATHELAS INSTITUTE, INC.

APPLICATION FOR SERVICES

(Please Print or Type)

(Circle program(s) for which application is being submitted)

- ♦ Residential/Day/Vocational/Support Services
- ♦ Medical Day Care
- ♦ Respite Care.
- ♦ Educational

Applicant's Name: ____
Last First Middle Called by

Current Address: ____
Street City State Zip # of Years

Phone #: __( )________________

Permanent Address: ____
(If Different) Street City State Zip # of Years

Phone #: __( )________________

Date of Birth: ________________________ Place of Birth: _____________________
Mo. Day Year City & State

Applicant's Marital Status: ________________________

Applicant's Social Security # ________________________

Applicant's CBIS # *(if known)* ________________________

PARENT/GUARDIAN/CAREGIVER INFORMATION

Name: ____

Address: ____

City/State ____

Phone #: _( )____________________ Relationship to Applicant: ________________________

(Complete and return to:)

Athelas Institute, Inc.
Attention: Diane LaSov
9104 Red Branch Road Columbia, MD 21045

410/964-1241 Fax: 410/964-3140

REFERRED BY

Name: ____

Address: ____

City/State _________________________________ Phone #: __(   )__________________

Relationship to Applicant: ____

Does Applicant have a Service Coordinator? _____Yes ______No

If YES, Name & Phone #:

Does Applicant have a Legal Guardian? ______Yes ______No

If YES, Name & Phone # of Legal Guardian: ___________________________________

Date Guardianship obtained: ____

Type of Guardianship *(check whichever is applicable):*

____Full ____Property ____Limited ____Medical

APPLICANT LIVES WITH *(include names):*

Parents: ____

Guardian or Relatives: ____

Foster Home: ____

Other ____

Address: __________________________________ Phone #: _(   )__________________

EMERGENCY CONTACT

Name: ____

Address: ____

Phone #: __(   )__________________

Relationship to Applicant: ____

FAMILY INFORMATION

Father's Name: ______________________________ Birthdate: ____________________

Address: ___________________________________ Home Phone #: __(   )___________

Father's Occupation: __________________________ Work Phone #: __(   )___________

Work Address: ____

Father's Social Security #: __________________ Deceased: ___ Date: _____________

Father's Marital Status: _____ Married ______ Divorced

_____ Separated ______ Remarried Date:

Mother's Name: ______________________________ Birthdate: ____________________

Address: ___________________________________ Home Phone #: __(   )___________

Mother's Occupation: __________________________ Work Phone #: __(   )___________

Work Address: ____

Mother's Social Security #: __________________ Deceased: ___ Date: ____________

Mother's Marital Status: : _____ Married ______ Divorced

_____ Separated ______ Remarried Date:

Brothers and Sisters *(use back 0/ application/or additional names):*

Name: __________________________________ Date of Birth: ____________________

Address: _________________________________ Phone #: __(   )____________________

Occupation: ____

Name: __________________________________ Date of Birth: ____________________

Address: _________________________________ Phone #: __(   )____________________

Occupation: ____

FINANCIAL INFORMATION

Applicant's Medicaid *(Medical Assistance)* No.: ____

Applicant's Medicare #: ____

__________ Part A   ____________ Part B

Other Medical Insurance (specify company name and policy #):

____

____

____

SSI Claim Number: ____________________________ SSI Amount: ___________________

SSA Claim Number: ____________________________ SSA Amount: ___________________

Name of Wage Earner: ____

SSDI Claim Number: ____________________________ SSDI Amount: __________________

Name of Representative Payee, *if different from Applicant):* ____________________________

V.A. Claim Number: ____________________________ V.A.Benefits Amount: ____________

Name of Veteran: ____

Railroad Retirement Claim Number: ________________Railroad Retirement Amount: _______

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 #: ____

Name of Bank: ____________________________ Amount in Account: ___________________

Any Property in Applicant's Name: ______Yes ______No

If YES, give location and estimated value: ____

Trust Fund: ______Yes ______No _________________________ Type

If YES, give name and address of trustee: ____

Applicant's Earnings from Employment: Monthly Amount: ______________________________

MEDICAL INFORMATION

A. Applicant's Primary Health Care Provider/Physician: ________________________________

____

Address: ____ Phone #: __(   )_________________

Date of Applicant's Last Physical Exam: ____

Examined By: ____

Address *(if different from above)*: ____

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

C. Seizures:

1. Does Applicant have seizures? ____Yes ______No

2. Frequency *(circle one):* . ♦ Daily. ♦ Weekly. ♦ Other .

♦ At least once a month. ♦Every few months

3. Type of seizure: ____

4. Are seizures controlled by medication? Yes No

E. Applicant: ____Walks _____Uses Cane ______Uses Crutches

______Uses Walker Uses Wheelchair: ___Manual _____Electric

F. Vision:

1. Any vision impairment? ____Yes _____No

2. Does Applicant wear glasses or contact lenses: ____Yes _____No

3. Date of last eye examination: ____

4. Comment(s) ____

Legally Blind: ____Yes _____No

G. Hearing:

1. Does Applicant have hearing Problem ____Yes ____No

2. Does Applicant wear a hearing aid? ____Yes ____No

3. Date of last hearing evaluation ____

4. Comment(s) ____

Deaf ____Yes ____No

H. Dental:

1. Date of last dental examination: ____
.
2. Does Applicant wear dentures: ____Yes ____No

3. Brief description of any dental problem(s) ____

I. Speech and Language Information:

1. Does Applicant have any speech/language impairment? ____Yes ____No
2. Is Applicant verbal? ____Yes _____No
3. Has Applicant had any speech/language Assessment? ____Yes ____No
4. Done by: ____
5. Means of communication: Speech Sign Language Gestures Communications Board Other

J. List any allergies (bee stings, drugs, dust, mold; food; etc.)

____

____

Does Applicant have any other medical problems not listed above? If YES, please list.

____

____

____

Does Applicant have a history of alcohol or substance abuse? ____Yes ____No

List previous treatment and date: ____

____

PSYCHOLOGICAL INFORMATION

A. Date of last psychological evaluation: ____

1. Performed by: ____

   Address: ____

2. Diagnosis: ____

B. Has Applicant received any mental health services *(i.e., counseling, outpatients or inpatient psychiatric services)* ?

____Yes ____No

Describe: ____

____

D. Does Applicant have a history of behavioral problems? ____Yes ____No

If so, describe using the chart below:

Behavior Problems	Frequency	Severity	Intervention

E. Has the Applicant ever been convicted of a crime? ____Yes ____No

If yes, provide details:

____

____

F. Any other family members diagnosed as having a disability?

Yes No If YES, describe:

BACKGROUND INFORMATION

A. Name of School(s) attended | Complete Address | Dates

Name of School(s) attended	Complete Address	Dates

Contact person: ____

B. Adult Program(s) Attended | Complete Address | Dates

Adult Program(s) Attended	Complete Address	Dates

Contact person: ____

C. Vocation Training or Evil. | Complete Address | Dates

Vocation Training or Evil.	Complete Address	Dates

Contact person: ____

D. Residential Program/Institutional Placement: : ______________________________

____

____

Contact person: ____

E. Hospitalization/Rehabilitation Placement: ______________________________

____

____

Contact person: ____

SKILLS CHECKLIST

A. Is Applicant independent in personal self-care skills?

____Yes ____No

If needs assistance, describe: ____

B. Can Applicant self-medicate? ____Yes ____No

C. Can Applicant cross streets: Independently Requires Assistance

_____ Not Capable

D. Can Applicant use mass transit *(Le., bus, metro)?*

____Independently ____Requires Assistance ____Not Capable

E. Is Applicant independent in personal self-care skills?

Yes No How Long?

F. Can Applicant read? Yes No Level

Signature of Parent/Guardian *(if applicable):* ______________________ Date: ___________

Signature of Applicant *(if at least*]8 *years of age):* __________________ Date: ___________

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 handicap. The following information is required for statistical purposes only; completion of this page is voluntary.

Religion: ______________________

Ethnic Identification *(check as applicable):* _____ Black _____ Caucasian

_____ Hispanic _____ Native American _____ Asian _____ Other

U.S. Citizen? _____ Yes _____ No

Sex: _____ Height: _____ Weight: _____

Color Eyes: _____ Color Hair _____ Identifying Marks: _____

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

____

Crisis Request

____

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

Authorization to release/obtain information.

Date: ______________________________ Address: ______________________________________

Client: ______________________________ ______________________________________

D.O.B.: ______________________________

I ____________________________ hereby authorize ______________________________to release medical, psychological, social narrative and other pertinent information to ___________ _________________________ 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 requesting agency 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 _____________________________________ Date _________________________
(must sign if client is under 18 years)

Witness: ____ Date _________________________
(must sign if "X" is used)

Agency Representative ______________________________ Date _________________________

Please complete the following information to help us get a clear idea of the Applicant's abilities.

Please check (√) how often the applicant completes each of the following activities without help, supervision, or frequent reminders. Please note: Applicants with very severe disabilities may be able to do few or none of the activities.

	Always or Almost Always	**Sometimes**	**Rarely or Never**	**Not Applicable**
Follows one-step instruction				
Requests help when needed				
Prints or writes first and last name				
Locates or remembers phone numbers				
Deals with simple injuries such as cuts				
Communicates home address				
Calls others on phone				
Selects seasonally appropriate clothing				
Responds appropriately to most common posted signs, printed words or symbols (For example: STOP, MEN, WOMEN, DANGER)				
Obtains emergency help when needed (For example, calls 911)				
Answers telephone and takes messages reliably				
Knows value of change (for example nickel, dime, quarter)				
Obtains a doctor's help when needed				
Uses a watch or clock daily to do something at a correct time (for example, watch a TV program)				
Is safe if left at home alone for an evening				
Prepares grocery list for at least six items				
Crosses nearby residential streets, roads and unmarked intersections alone				
Finds way in the neighborhood				
Washes and dries dishes and puts them away				
Mixes and cooks simple foods such as scrambled eggs, soup or hamburgers				
Correctly counts change from a five dollar bill after making a purchase				
Purchases at least six items from grocery store				
Cleans bedroom, including putting away clothes				
If public transportation is available, uses it independently				

Finds way in the neighborhood				
Takes proper medication at proper time				
Budgets money to cover expenses for at least one week (recreation, transportation and other needs)				

(continued on next page)

Please check (./) how much of a problem the following are for the Applicant:

	Not a Problem	**Mild Problem**	**Moderate Problem**	**Severe Problem**
Physical harms others				
Harms self (bites, hits, etc.)				
Destroys property or objects				
Is sexually aggressive with others				
Abuses alcohol or drugs				
Has repetitive or unusual habits				
Engages in socially offensive behavior				
Engages in irritating behavior				
Verbally abuses others				
Is sexually exploited by others				
Is physically exploited by others				
Is victimized verbally or emotionally by others				