Print Form

For Office Use Only
Date Received _____Date Approved _____

POINT OF HOPE, INC
Application for Services

SECTION I: APPLICANT

Applicant's Name_____ AKA_____
Current Residence_____
County_____ Home Telephone No._____
Date of Birth _____ Sex _____
Social Security # _____ U.S.Citizen Yes__ No__
DDDS Funding Eligibility Approved ____ Applied For____ Other____
Social Security Benefits: SSI__ SSD__ Other __
Medicare (if Yes, give #) _____ Medicaid (if Yes, give #)_____
Other Medical Insurance (give name and number) _____
_____

Current Day Program/Employment/School _____
Address _____
Telephone No _____Date of Graduation_____
Current Residential Program _____
Address _____
Telephone No._____
Previous educational, vocational and residential experience (list schools, programs, institutions, hospitals etc and dates with the most recent first: _____
_____
_____
_____
_____

Referring Agency_____
Contact _____ Phone No: _____
Parents Name _____
Address _____
Home Phone _____Work Phone _____
Name of Guardian if other than parents _____
Guardian's Address _____
Phone #_____

SECTION II: MEDICAL PROFILE

List all diagnoses and dates _____
_____
_____

Physician _____
Address _____ Phone #_____

Current Medications _____

	Yes	No
Does Applicant have speech?	☐	☐
Can applicant make himself/herself understood?	☐	☐
If non-verbal, how does applicant make his needs known (communication board, gestures, or sign language)?	☐	☐
Does applicant have difficulty hearing?	☐	☐
If any hearing loss, to what extent?	☐	☐
Does applicant have any vision problems?	☐	☐
If any visual impairment, to what extent?	☐	☐
Does applicant wear glasses/contact lenses?	☐	☐
Does applicant walk?	☐	☐
Does applicant use a walker?	☐	☐
Does applicant use a wheelchair?	☐	☐
Does applicant have good use of his/her left hand?	☐	☐
Does applicant have good use of his/her right hand?	☐	☐

Nature of Disability_____
_____
_____
_____
_____

Does applicant have any chronic illnesses? Yes ○ No ○
If yes, list chronic illnesses:_____
_____
_____
_____

List any adaptive equipment used by the applicant _____
_____
_____

List any functional aids or prosthesis currently used by the applicant _____
_____
_____

Does applicant have any behavior problems? Yes ○ No ○
If applicant had behavior problems, please list in order of severity _____
_____
_____

Is applicant receiving counseling for behaviors? If so, give counselors name, address and phone number _____
_____
_____

SECTION III: DEVELOPMENTAL STATUS

Please check the level of assistance required by the applicant in the following areas:

	Always	Sometimes	With Assistance	Unable To Do
Feeds self	☐	☐	☐	☐
Drinks Independently	☐	☐	☐	☐
Toilets Independently	☐	☐	☐	☐
Dresses Self	☐	☐	☐	☐
Bathes Self	☐	☐	☐	☐
Shampoos Hair	☐	☐	☐	☐
Shaves Self	☐	☐	☐	☐
Takes care of Menstruation	☐	☐	☐	☐
Is able to Self Medicate	☐	☐	☐	☐
Is able to select weather appropriate clothing	☐	☐	☐	☐
Changes clothing daily	☐	☐	☐	☐
Makes own bed	☐	☐	☐	☐
Cleans bedroom	☐	☐	☐	☐
Does Laundry	☐	☐	☐	☐
Can prepare a simple breakfast	☐	☐	☐	☐
Can make a sandwich	☐	☐	☐	☐
Responds to one step instructions	☐	☐	☐	☐
Expresses needs verbally	☐	☐	☐	☐
Is able to tell time	☐	☐	☐	☐
Can handle money and make change	☐	☐	☐	☐
Knows how to use a savings or checking account	☐	☐	☐	☐
Is able to use public transportation	☐	☐	☐	☐
Can give name, address and phone number	☐	☐	☐	☐
Can write name	☐	☐	☐	☐
Can read and comprehend simple printed matter	☐	☐	☐	☐

Signature of Applicant/Designee _____ Date_____