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
- ❑ Individual Support Services

CHILDREN SERVICES

- ❑ Respite Care
- ❑ In-Home Supports for Children

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: ___________________________

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:_________________________________

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:____

List all Bank Accounts that are held either solely by the applicant or jointly with another party:
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:____

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):____

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: ____

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

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.

AUTHORIZATION TO OBTAIN INFORMATION

Date authorization becomes effective: __________________ and expires on _________________.

I, ____ hereby authorize

(Clinician/Doctor/Evaluator name and address):

____

____

Phone number:_______________________

to release the following : _____ Social History _____ Psychological Reports _____Vocational Evaluations

_____Medical Information _____Counseling Reports _____Other (specify below)

____ to Richcroft Inc., 11350 McCormick Rd., Exective 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

Richcroft, Inc.
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