

11/02

Mail to  
The Arc of the Piedmont  
509 Park Street Charlottesville, VA 22902  
(800) 732-9507

## The Arc of the Piedmont APPLICATION FOR ADULT SERVICES

Check the services for which you are applying:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 1014 Locust Ave, C'ville       | <input type="checkbox"/> 1100 Locust Ave, C'ville | <input type="checkbox"/> Jefferson Park Circle                   |
| <input type="checkbox"/> Jarman's Gap Road, Crozet      | <input type="checkbox"/> 210 E. Main, Louisa      | <input type="checkbox"/> Stevens-Varnum House, ICF/MR, Lovingson |
| <input type="checkbox"/> Center-based Respite           | <input type="checkbox"/> In-Home Respite          | <input type="checkbox"/> In-Home Residential Care                |
| <input type="checkbox"/> Wiseman House, ICF/MR, C'ville | <input type="checkbox"/> Adult Activity Center    | <input type="checkbox"/> Consumer-Directed Services              |

**Applicant Full Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, Zip Code:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Race:** \_\_\_\_\_

Applicants: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Marital status:  Married  Single  Divorced

Has the court named someone as the legal guardian?  Yes  No

**If so, give the guardian's name, address and phone number:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Criminal Justice Status:** \_\_\_\_\_

### EMERGENCY CONTACT PERSON:

**NAME:**

**ADDRESS:**

**CITY, ZIP CODE:**

**TELEPHONE (day):**

**TELEPHONE (night):**

**RELATIONSHIP:**

**MEDICAID #**

**MEDICARE #**

**WAIVER**

**OTHER INSURANCE; (NAME OF COMPANY):**

**GROUP #**

**POLICY #**

**FOR OFFICE USE ONLY:** Date application was received: \_\_\_/\_\_\_/\_\_\_

**Admission Date:** \_\_\_/\_\_\_/\_\_\_

**Discharge Date:** \_\_\_/\_\_\_/\_\_\_

**SOCIAL & DEVELOPMENTAL SUMMARY**  
PLEASE USE THE BACK OF THIS FORM IF MORE SPACE IS NEEDED

**Describe the Applicant's Previous Service History** (what programs have they been in, when, for how long):

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**Describe the Applicant's current behavioral functioning including strengths & needs** (what can they do what do they need to learn):

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**Documentation of need for service** (Describe what the Applicant and Family hope to gain by participating in the service):

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**FAMILY SUMMARY**

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone # (home): \_\_\_\_\_

\_\_\_\_\_ Telephone # (work): \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone # (home): \_\_\_\_\_

\_\_\_\_\_ Telephone # (work): \_\_\_\_\_

Brothers & sisters (name, age, sex): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other relatives interested/involved with client: \_\_\_\_\_

**Describe the applicant's current family structure and relationships. Also describe the anticipated future involvement of the applicant's family (i.e, visits, phone calls, updates by staff):**

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Describe the applicant's typical social activities, food and entertainment preferences, and interactions with others:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Is the applicant's family interested in volunteering within the program?** \_\_\_\_\_

**MEDICAL HISTORY**

**Indicate if the Applicant has any of the following illnesses and/or chronic conditions**

- YES \_\_\_ NO \_\_\_ **A.** Epilepsy, CP, MS, Parkinson’s, Neuritis, Paralysis, Alzheimer’s disease or any other disease of the Central Nervous System.
- YES \_\_\_ NO \_\_\_ **B.** Heart attack, murmur or palpitation or high blood pressure, anemia, varicose veins, or any other disease of the heart, blood or blood vessels.
- YES \_\_\_ NO \_\_\_ **C.** Tuberculosis, asthma, pleurisy, or any other disease of the lungs, bronchial tubes, throat or respiratory system.
- YES \_\_\_ NO \_\_\_ **D.** Ulcer, indigestion, colitis, gall stone, hernia or any disease other of the stomach, intestines, rectum, gall bladder or liver.
- YES \_\_\_ NO \_\_\_ **E.** Urinary sugar, albumin or stone, sexually transmitted disease, menstrual disorder, or any other disease of the breasts, kidneys, prostate, urinary or genital systems.
- YES \_\_\_ NO \_\_\_ **F.** Diabetes, gout, or any other disease of the thyroid or other glands.
- YES \_\_\_ NO \_\_\_ **G.** Arthritis, rheumatic fever, back trouble or any other disease of the joints muscles or bones.
- YES \_\_\_ NO \_\_\_ **H.** Clinical Depression, , Schizophrenia, Bipolar Disorder, or any mental illness.
- YES \_\_\_ NO \_\_\_ **I.** Mental Retardation, Autism, or any other developmental disability.

**Current significant medical problems, communicable diseases, or recent physical complaints of Applicant, if any:**

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**Past significant medical problems of Applicant, if any (serious injuries or serious illnesses, or hospitalizations):**

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**Serious illnesses or chronic conditions of the Applicant’s parents, siblings, and others in the same household, if any:**

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**Applicant’s substance abuse history including, onset of use, types of substances, frequency of use, quantity of use, method of administration, if applicable:**

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**NAME, ADDRESS AND TELEPHONE NUMBER OF APPLICANT'S PHYSICIAN:**

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**MEDICATION PROFILE**

**LIST APPLICANTS CURRENT PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS**

**A COPY OF CURRENT PHYSICIAN'S ORDER WITH DOCTOR'S SIGNATURE MUST BE ON FILE IF STAFF ARE REQUIRED TO GIVE THE MEDICATION:**

NAME	DOSAGE	TIMES TAKEN	REASON	SIDE EFFECTS

**LIST APPLICANT'S DRUG OR FOOD ALLERGIES:**

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**ARE THERE ANY MEDICATIONS OR TREATMENTS THAT THE APPLICANT SHOULD NOT HAVE? (Please list all):**

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**History of Seizures?**

YES       NO       UNKNOWN

Are seizures under control?

YES       NO       PARTIALLY       UNKNOWN

Are seizures controlled

with medication?       without medication?

**SERVICE NEEDS –Please check applicable boxes**

**(Attach copy of Inventory for Client and Agency Planning, if available)**

**Applicant can function without supervision for:** Up to 15 minutes  Up to 1 hour  All day   
 Overnight  48 hours  with weekly contact  Other: \_\_\_\_\_

**Motor skills:**

How frequently does applicant require support or assistance in walking or standing?

<b>Rarely</b>		<b>Sometimes</b>	
<b>Often</b>		<b>Always</b>	

Does the Applicant use a:  Walker  Wheelchair  Other equipment \_\_\_\_\_

**Social and communication skills:**

How frequently does applicant require support or assistance in making his or her needs known or getting along with others?

<b>Rarely needs help</b>		<b>Sometimes needs help</b>	
<b>Often needs help</b>		<b>Always needs help</b>	

What is the applicant's primary means of communication?

<b>Verbal Speech</b>		<b>Sign Language</b>	
<b>Gesture, Communication Board</b>		<b>Vocalization (no speech)</b>	

**Personal Living Skills:**

How frequently does the applicant require support or assistance with eating, dressing, using the bathroom, or personal hygiene?

<b>Rarely</b>		<b>Sometimes</b>	
<b>Often</b>		<b>Always</b>	

**Community Living Skills:**

How frequently does the applicant require support or assistance with being safe around traffic, recognizing an emergency, telling time, shopping, or working?

<b>Rarely</b>		<b>Sometimes</b>	
<b>Often</b>		<b>Always</b>	

**Intellectual Functioning:**

<b>Mild Mental Retardation</b>		<b>Moderate Mental Retardation</b>	
<b>Severe Mental Retardation</b>		<b>Profound Mental Retardation</b>	
<b>Unknown</b>		<b>Does not have Mental Retardation</b>	

**Behavioral Supports:**

Please describe any behavioral supports that have proven to be successful for the applicant:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HISTORY OF RESIDENTIAL TREATMENT OR INSTITUTIONALIZATION:**

Name of Agency or Institution	Address	Dates (to/from)

**Other Social Service Agencies/Professionals Involved with Client:**

Agency/Professional	Dates (to/from)	Contact Person

**Additional comments:**


**This form must be accompanied by the following (check box if information is present):**

- |  |   |
|--|---|
| <p><b>1. Report of physical, which includes:</b></p> <ul style="list-style-type: none"> <li>a. General physical condition <input type="checkbox"/></li> <li>b. Evaluation for communicable diseases <input type="checkbox"/></li> <li>c. Recommendations for further treatment <input type="checkbox"/></li> <li>d. Other examinations indicated and <input type="checkbox"/></li> <li>e. The date of exam and signature of medical provider <input type="checkbox"/></li> </ul> | <p><b>2. ICAP (CSB case manager can provide) <input type="checkbox"/></b></p> |
|--|---|

**Form completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Applicant:** \_\_\_\_\_