**Application for Services**

Name of Individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name Middle Initial First Name

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

 Street Address City Zip Code

Phone Number: Alternative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Sex: Male Female

Social Security #: Medicaid #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Divorced Widowed

Primary Language: English Spanish Other: \_\_\_\_\_\_\_\_\_\_\_

Communication Mode: Verbal Non-Verbal

Communication Device(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Last Name First Name

Relationship to Individual: Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Background Information**

Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City County State

Legal Status: Child Competent Adult Adult with Legal Guardian

Name of Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name

Address of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address City Zip Code

Phone Number of Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobility & Self Care**

**Mobility (Check One):**

|  |  |
| --- | --- |
|  Walks Independently  |  Walks with Assistance From Others  |
|  Requires walker, crutches, or cane  |  Uses Wheelchair Independently |
|  Uses Wheelchair with Assistance |  |

**Eating (Check One):**

|  |  |
| --- | --- |
|  Eats Meals Independently  |  Requires adaptive eating utensils  |
|  Requires assistance to eat |  Must be tube fed  |

**Dressing (Check All that Apply):**

|  |  |
| --- | --- |
|  Dresses Independently  |  Requires assistance with buttons, zippers or snaps |
|  Requires assistance when picking out appropriate clothing |  Requires assistance with socks and shoes |
|  Requires total assistance |  |

**Bathroom (Check One):**

|  |  |
| --- | --- |
|  Restrooms Independently |  Requires Verbal Reminders  |
|  Requires assistance with clothing and/or wiping in restroom |  Has a bowel and bladder program |
|  Has Catheter  |  Has a Colostomy Bag |

**Grooming/Hygiene(Check all that apply):**

|  |  |
| --- | --- |
|  Showers/Bathes Independently |  Requires Assistance with water temperature |
|  Requires Verbal Reminders to wash/rinse hair  |  Must be closely supervised in shower/bath |
|  Brushes Teeth Independently |  Requires verbal reminders to brush teeth |
|  Requires Assistance to brush teeth |  Unable to brush teeth |
|  Combs/brushes hair independently  |  Requires assistance to comb hair  |
|  Puts on deodorant, perfume/cologne Independently  |  Requires assistance with deodorant, perfume/cologne |
|  Trims nails Independently  |  Requires assistance to trim nails |
|  Shaves independently  |  Requires assistance with shaving |

**Meal Preparation/Planning(Check all that apply):**

|  |  |
| --- | --- |
|  Cooks simple meals independently |  Uses microwave independently |
|  Able to follow recipe |  Able to make toast/sandwich |
|  Requires assistance to prepare meals  |  Unable to prepare any food |

**Socialization/Community(Check all that apply):**

|  |  |
| --- | --- |
|  Interacts with peers independently  |  Requires prompting to interact  |
|  Withdrawn/keeps to self  |  Can travel in community independently |
|  Requires minimal supervision in community |  Requires close supervision in community |

**Medical Information**

General Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name First Name

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

Street Address City Zip Code

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialists Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Street Address City Zip Code

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Allergies(food,medications,environmental):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

List all Diagnoses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past surgeries/medical procedures:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Seizures: No Yes If yes,frequency and type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet: No Yes If yes, type of diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Hearing Problems: No Yes If yes, describe type and devices:\_\_\_\_\_\_\_\_\_\_\_\_

Vision Problems: No Yes if yes, describe type and aids:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

. .

**Medications**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage/ Frequency** | **Reason** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

By signing below, I agree and affirm that all information is correct and up to date. I understand and affirm that I am responsible to update Next Step Transition Center to any changes to this information.

Name of Individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name Middle Initial First Name

Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAR/Guardian Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next Step Administrative Staff Signature: Date:\_\_\_\_\_\_\_\_\_\_ .

**Individual Releases**

Name of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY/MEDICAL**

\_\_\_\_\_ I authorize the staff and contractors of Next Step Transition Center to seek medical assistance and treatment for myself or my individual in the event of an emergency.

**TRANSPORTATION**

 \_\_\_\_\_ I hereby give the staff and contractors of Next Step Transition Center permission to provide transportation to myself or my individual to scheduled activities, special events or in the case of an emergency.

**RELEASE FOR PHOTOS, AUDIO AND VIDEO TAPE**

 \_\_\_\_\_ I hereby give the staff and contractors of Next Step Transition Center permission to take and release pictures,films, and audio or video tape recordings of me/my son/daughter to assist in promoting and providing services for Next Step Transition Center.

By signing this document, I agree and affirm that I have read and completely understand all of the above releases.

Signature of Individual/LAR/Legal Guardian Date