The Arc of Baltimore
Application for Services
(Please Print or Type)

Date of Application: ___________________

Check program(s) for which application is being submitted.

- ❑ Day/Vocational
- ❑ Medical Day Care
- ❑ Family Support Services
- ❑ Residential
- ❑ Respite Care
- ❑ Supported Living
- ❑ Supported Employment

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

Telephone #:________________________________

Baltimore City/County of Residence:____________________________

Social Security #: ____________________________

Type of Income/Amount:______________________

Medicare #:____________________________________

Medical Assistance #:_________________________________

Other Health Insurance:____________________________

Prescription Coverage:____________________

Does Applicant have a Service Coordinator? ___________

____

Name Phone #

PARENT/GUARDIAN/CAREGIVER INFORMATION

Name: ____

Address:____

City/State: ____

Phone: ____________________________________

Relationship to Applicant: ____________________

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

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:________________________________

Applicant's Bank Account:_________________________

Bank Name:____________________________

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

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 ❑ Manual ❑ Electric

G. Vision

1. Any vision impairment: ❑ YES ❑ NO
2. Does applicant wear glasses or contact lenses? _______________
3. Date of last eye exam:___________________
4. 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):

    ____

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

J. Allergies (bee stings, drugs, dust, mold, food, etc.)

____

____

Does applicant have any other medical problems not listed?

____

____

____

____

MENTAL HEALTH

1. Does applicant have a history of mental health, 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)

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?

❑ No ❑ 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?

____

____

____

____

____

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

The Arc of Baltimore 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

____

-Waiting List Equity

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 RELEASE/OBTAIN INFORMATION

Date: ______________________

Name of person with developmental disability: _____________________

D.O.B.______________

Address:
____

____

I, _______________________, hereby authorize _______________________

Doctor's Name,
Clinic/Hospital Name
or other pertinent
professional/agency

____
Address with Zip Code

____
Phone Number

to release medical, psychological, social narrative and other pertinent information to the Arc of Baltimore 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 Arc of Baltimore 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 (must sign if client is under 18)	Date
Witness (must sign if “X” is used)	Date
Agency Representative	Date

Advocacy, resources and community for people with developmental disabilities
7215 York Road/Baltimore, Maryland 21212-4499/ (410) 296-2272 / Fax (410) 296-2394 / TTY (410) 296-6372
www.arcofbaltimore.org