



APPLE PATCH

“Promoting a life of independence for adults with intellectual disabilities”

PROGRAM APPLICATION

Please check which program is being applied for:

- Adult Day Training Case Management
 Residential Services Other: _____

SECTION 1: PERSONAL INFORMATION

Applicant's Name: _____

Current Address: _____

City, State, and Zip Code: _____

Phone: _____

Date of Birth: _____ SSN: _____

Sex: _____ Height: _____ Weight: _____

Legal Status: Adjudicated
 Non-adjudicated

SECTION 2: GUARDIAN INFORMATION

Guardian Name: _____

Relationship to Applicant: _____

Address: _____

City, State, and Zip Code: _____

Phone (Day): _____ Phone (Evening): _____ Cell: _____

Email Address: _____

SECTION 3: FAMILY INFORMATION

Father: _____ **DOB:** _____

Address: _____

City, State, and Zip Code: _____

Phone (Day): _____ **Phone (Eve.):** _____ **Cell:** _____

Email Address: _____

SSN: _____ **Place of Employment:** _____

Mother: _____ **DOB:** _____

Address: _____

City, State, and Zip Code: _____

Phone (Day): _____ **Phone (Eve.):** _____ **Cell:** _____

Email Address: _____

SSN: _____ **Place of Employment:** _____

Siblings/Significant Others:

Name: _____

Relationship to Applicant: _____

Address: _____

Phone: _____ **Email:** _____

Name: _____

Relationship to Applicant: _____

Address: _____

Phone: _____ **Email:** _____

SECTION 4: EDUCATIONAL BACKGROUND

School	Year Completed	Degree/Diploma
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 5: WORK HISTORY

Current Employer: _____

Address: _____

Length of time in employment: _____

Work Schedule: _____

Previous employment or day program(s) (please list):

SECTION 6: COMMUNITY ACTIVITIES

Please list involvement in any clubs, volunteer work, church participation, athletics, etc.:

SECTION 7: HEALTH AND MEDICAL INFORMATION

Diagnoses: _____

Please describe general health: _____

Medications:

Name	Dosage	How often	Purpose	Physician

Allergies: _____

Diet restrictions: _____

Physicians Name: _____ **Phone:** _____

Dentists Name: _____ **Phone:** _____

Psychiatrists Name: _____ **Phone:** _____

Please describe any behavioral issues: _____

SECTION 8: DAILY LIVING SKILLS

Communication (please check appropriate box):

- Verbal
- Verbal but difficult to understand
- Non verbal but uses gestures
- Sign Language
- Non verbal and does not understand others
- Augmentative communication device

SECTION 7: HEALTH AND MEDICAL INFORMATION

Adaptive Devices (check all that apply):

- Wheelchair**
- Walker/Cane**
- Glasses**
- Hearing Aid**
- Dentures**
- Other (please list):** _____

Please place the appropriate letter next to the skill to indicate the level of functioning for that particular skill:

I= Independent A=Assistance D=Dependent

Eating		Dressing	
Grooming		Bathing	
Transferring		Setting the table	
Shopping		Cooking	
Reading		Writing	
Transportation		Use of telephone	
Handling money		Banking	

SECTION 8: GENERAL INFORMATION

Likes: _____

Dislikes: _____

Areas of Difficulty: _____

Strengths: _____

Other (please list any information you feel would be beneficial): _____

SECTION 9: FINANCIAL INFORMATION

Personal Income received by the applicant:

SSI benefits: _____

SSDI benefits: _____

Other (please specify): _____

Payee/Fiduciary Name: _____

Address: _____

Phone: _____

Applicant's signature: _____

Date: _____