

Independence Association, Inc.

Application for Services

Nondiscrimination notice

Independence Association does not discriminate on the basis of race, color, national origin, or physical or mental handicap in admission or access to, treatment of employment in its programs or activities.

***Note of Importance:** When filling out this form, please keep in mind that the entire form needs to be completed. It is imperative that we obtain all pertinent information for our records so that this information can be accessed when needed.

***For additional information please visit our web site at www.independenceassociation.org**

Name of person completing form: _____

Who referred you to our services (or where did you hear of us): _____

APPLICANT INFORMATION:

Name: _____
(Last) (First) (MI)

Address: _____
(Street) (Town) (State) (Zip Code)

Phone #: _____ E-Mail Address: _____ Date of Birth: _____

Disability: Primary _____
Secondary _____ Other Medical Disabilities: _____

GENERAL INFORMATION:

Hair Color: _____ Eye Color: _____ Weight: _____

Height: _____ Sex _____ Distinguishing Marks/Scars: _____

Marital Status: _____

Are you your "own" guardian? Yes No

If no, name of guardian _____ Phone: _____

Guardian Address _____
(Street) (Town) (State) (Zip Code)

Are you a consumer of DHHS? Yes No

Caseworker's (ISC) Name: _____ Phone: _____

Are you a consumer of Vocational Rehabilitation? Yes No

Counselor's Name: _____ Phone: _____

Are you a consumer of DMH? Yes No

Caseworker's Name _____ Phone: _____

Do you have a Community Case Manager? Yes No

Community Case Manager's Name: _____ Phone: _____

FINANCIAL INFORMATION:

Social Security # _____ Are you your own representative payee? Yes No

If no, Name of Representative Payee _____ Phone _____

Address _____
(Street) (Town) (State) (Zip Code)

_____ SSI \$ _____

_____ Maine Care, # _____

_____ SSDI \$ _____

_____ Medicare, # _____

_____ AFDC \$ _____

_____ Medicare Part "D"

_____ Unemployment, \$ _____

If yes, Plan Name: _____

Plan Number: _____

MEDICAL/DISABILITY INFORMATION:

Adaptive equipment/aids used:

_____Glasses/contact lenses _____Wheelchair
_____Hearing aid(s) amplifier _____Augmentative speech devices
_____Braces/ crutches _____Other, specify_____

List any medication(s), and schedule of administration:_____

Can you administer your own medication(s)? Yes No If yes, for how long?_____

Do you have allergies? Yes No If yes, specify_____

Significant medical history (please include major illnesses, surgeries, or accidents)

Date:_____Specify:_____

Date:_____Specify:_____

Date:_____Specify:_____

Date:_____Specify:_____

Do you have any special travel needs? Yes No If yes, please specify_____

Do you have any special needs? Yes No If yes, please specify_____

(E.g. Medical/physical limitations, diet, hearing, sight, physical exertion limitations, etc.)

Physician Information:

Date of last **Physical Exam:** _____ Primary Care Physician: _____

PCP Address: _____
(Street) (Town) (State) (Zip code)

Phone: _____

In the event of an emergency, should the Primary Care Physician be contacted? Yes No

If no, please indicate PCP to be notified _____
Full Name

Address _____ Phone _____

Date of last **Psychological/Psychiatric evaluation:** _____ Examiner: _____

Examiner's Address: _____
(Street) (Town) (State) (Zip Code)

Phone: _____

Date of last **Dental Exam:** _____ Dentist: _____

Dentist's address: _____
(Street) (Town) (State) (Zip Code)

Phone: _____

Pharmacy Information:

Name of Pharmacy: _____ Phone: _____

Address: _____
(Street) (Town) (State) (Zip Code)

Emergency/Disaster Information:

In the event of an emergency/disaster, who would be the contact person? _____

In an emergency/disaster, please indicate the hospital you wish to provide the treatment:

Name of Hospital Phone

If the individual must be evacuated from their home, or located away from their home during a disaster, the following options may be used: **(Please be as specific as possible)**

First Choice Contact Person: _____ Phone: _____

First Choice Location: _____ Phone: _____

Additional Evacuation Information: _____

Special Needs: (Please indicate **any** medications, or medical devices this person would need in the event of an emergency/disaster) _____

FAMILY INFORMATION:

Please list any of your significant family members, spouse, correspondents and others, who live with or are involved in your life.

Name Relationship Home Phone

Address Business Phone

E-Mail Address: _____

Name Relationship Home Phone

Address Business Phone

E-Mail Address: _____

Name	Relationship	Home Phone
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Address	Business Phone
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E-Mail Address: _____

EDUCATIONAL INFORMATION:

What school are or did you attend? _____

Date of last year you attended this school/program: _____ Current grade level _____

Did you receive a **Certificate:** _____ **Diploma:** _____

Academic/functional skills: **(Briefly estimate your skills)**
(E.g. excellent, good, fair, poor)

Writing _____ Personal Care _____

Reading _____ Money Management _____

Independent Living Skills (Cooking, cleaning, etc.) _____

SERVICES INFORMATION:

Reason(s) for applying for services: _____

Will you need assistance arranging transportation? Yes No

If yes, please specify your needs: _____

Please indicate below which service(s) you wish to receive:

Residential Services:

Supported Living _____

Residential _____

Personal Support _____

Children's Services:

Children's In-Home Services_____

Children's Targeted Case Management_____

Day Services:

Learning Center Initiative_____

Spindleworks_____

Employment_____

Community Connections & Therapeutic Services_____

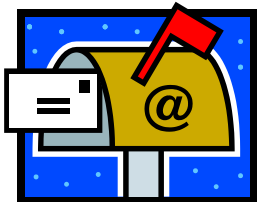
Other Services:

Adult Community Case Management_____

Adult/Children In-Home Supports_____

Learning Center_____

Other, specify_____



Please mail or return application to:

Independence Association, Inc.

P.O. Box 642

Brunswick, ME 04011

Attention to:_____

For Office Use Only:

Date application received:_____

Name of person receiving application:_____

Application forwarded to:_____ Date forwarded:_____