Ready For Life
belong · believe · become

Start Date:_____

Skill Building Applicant Information

(to be completed by family member/guardian)

Last Name	First Name	Middle Name
Home Phone	Cell Phone	
Street Address		County
City	State	Zip
Birth Date	Medicaid #	
Email Address	Medicare #	

Applying for:

Life Skills _____ Work Skills ___ No. of Days Requesting _____ T-shirt Size _____

Days Requesting M ___ Tu ___ W ___ Th ___ F ___

Applicant receives support or services from: (please check all that apply)

____ Supplemental Security Income
____ Social Security Disability Insurance
____ Community Mental Health
____ Vocational Rehabilitation Services
____ Medical Assistance
____ Other: _____

Check all that apply:

____ I am my own Guardian
____ My parents have Power of Attorney
____ My parents are my Guardian
____ We have not filled out guardianship paperwork
____ My Guardian is _____

All documents supporting the above checked boxes must be included with this application.

School/Agency Information

List the name(s) of high school(s)/transition programs and years of attendance.

Names of High School(s), City & State	Years of Attendance

****

Application Completed by: _____ Date completed: _____

Please provide the following information about your Community Mental Health Agency

CMH Agency	Main Phone
Street Address	City, Zip
Caseworker(s)	Direct Phone
E-mail address	Other

Family/Living Information

Applicant lives with ☐ Both parents ☐ Mother ☐ Father ☐ Guardian(s) ☐ Group Home

Family History

Mother/Guardian #1

Last Name	First Name
Home Phone	Cell Phone
Work Phone	Email address

Father/Guardian #2

Last Name	First Name
Home Phone	Cell Phone
Work Phone	Email address

Group Home

Name	Phone
Street	City, Zip
Contacts	Email addresses

Siblings or Other Group Home Residents

Name	Age	Name	Age

Emergency Contact Information – if contacts above cannot be reached

Name	Phone
Relationship	

Name	Phone
Relationship	

Personal Statement

(to be completed by applicant with assistance from a parent or guardian)

What type of jobs are you interested in? _____
_____

What do you like to do in your free time? _____
_____

What is your favorite hobby or sport? _____
_____

What other interests do you have? _____
_____

Below, please describe some of the skills you would like or need to learn.

Independent living (e.g., cooking, housekeeping) _____
_____

Academics (e.g., reading, calculating, budgeting) _____
_____

Social education (e.g., making friends, going places) _____
_____

Work skills training (e.g., applications, job experiences, interview skills) _____
_____

Safety training (e.g., stranger danger, community & transportation) _____
_____

Please provide answers to the following questions.

Applicant likes_____

Applicant dislikes_____

Applicant's strengths and gifts _____

_____

What is difficult or fearful for the applicant _____

_____

Significant medical or physical conditions which may affect your participation in classroom, social or recreational activities _____

Medications the staff should know about _____

Behavioral challenges the applicant might experience _____

_____

Special help needed for applicant's personal needs _____

_____

Special staffing accommodations for the applicant (nurse,1:1 aide, etc.) _____

_____

How the applicant communicates his or her needs _____

_____

Important information you need to know about me _____

_____

Work/Volunteer Information

(to be completed by applicant with assistance from a parent or guardian)

Has the applicant demonstrated success in volunteer, supported or independent unpaid job experiences in the community or the school? Yes ☐ No ☐

If yes, please list volunteer/job experiences and level of support required. (Does the applicant require one-to-one supervision or periodic support to perform the job, or does she or he work independently)

Job Description	Dates of Experience	Level of Support	Reason for Leaving

If no, why has he/she not participated in school or community volunteer/unpaid job experiences?

Has the applicant held a paid job in the community? ☐ Yes ☐ No

If yes, please list the jobs held, the dates of employment, the level of support, wages received, and the applicant's reason for leaving.

Job Description	Dates of Employment	Level of Support	Wages Per Hour	Reason for Leaving

Does the applicant require specialized equipment, adaptations or modifications, or specific reinforces at the workplace? If so, please describe: _____

_____

Behavior Information

Does the applicant demonstrate satisfactory school/prior program attendance? ___ Yes ___ No

How often is the program missed for illness? _____

How often is the program missed for doctor appointments? _____

Does the applicant demonstrate satisfactory behavior? ___ Yes ___ No

If no, please describe the nature of the applicant's behavioral challenges: _____

_____

Has the applicant ever been suspended or expelled? ___ Yes ___ No

If yes, what was the nature of the offense? _____

How was the suspension or expulsion resolved? _____

Health Information

Male ____ Female ____ Height _____ Weight _____

Disability: (official diagnosis)

___Cerebral Palsy ___Autism/ASD ___Muscular Dystrophy ___Down Syndrome ___Spina Bifida

___Multiple Sclerosis ___Epilepsy ___Closed head injury ___Other/ Explain _____

Associated problems	Normal	Impaired	Describe
• Hearing Ability	_____	_____	_____
• Visual Ability	_____	_____	_____
• Memory	_____	_____	_____
• Time-Concept	_____	_____	_____
• Perceptual Ability	_____	_____	_____

Does the applicant have seizures? ____Yes ____No Frequency _____

Describe the seizures including length and severity _____

_____

Describe chronic health problems for which you see a doctor _____

_____

List any food or drug allergies or dietary restrictions_____

List routine prescriptions and over the counter medications (name, dose, frequency) _____

_____

***Note**: You must be independent in administering your medications.*

Insurance Information

Is the applicant covered by Medical Insurance? ____Yes ____ No

Name of Insurance Company _____
Card Holder Name _____
Policy Number _____ Contract Number _____
Preferred Hospital _____

Additional Medical Information you feel would be important regarding participation in the program.

Personal Support Inventory

Please rate the applicant in the following areas. If you are unsure about a skill, please select the "?" box.

Skill	*Requires complete assistance*	*Needs moderate assistance*	*Needs some assistance*	*Needs minimal assistance*	*Completely independent*	*?*
Caring for personal hygiene and grooming needs						
Dressing one self, including zippers and shoes						
Coping well with stress and anxiety						
Adjusting to new situations or environments						
Communicating needs in an appropriate manner						
Relating to others in a socially appropriate manner						
Handling conflict with another person						
Respecting persons in authoritative positions						
Follow verbal directions						
Follow written directions						
Agility, Mobility and movement capabilities						
Self-feeding						
Medication Assistance						

Has the applicant utilized assistive technology (voice recognition, dictation, iPad etc.? ☐ Yes ☐ No

If yes, what? _____