APPLICATION FOR SERVICES

Today's Date: ________________________

Name: _______________________________ Date of Birth: ________________________

Current Address: ____

City:_________________________________State:________________Zip:___________

Place of Birth:_________________________ Social Security Number:_________________

Telephone number:______________________ Additional Telephone Number:_____________

Person completing this Application____
(if different from applicant) (Printed) (Signature)

Referred by:____

Person to contact in case of emergency:

Name: _______________________________Relationship___________________________

Address: ____________________________Telephone(s)____________________________

Services

What services are requested at this time: Day, Residential, Supported Employment, Individual Support, Other: ____

Reason for referral or applying to Kent Center:

____

____

____

____

DISABILITY AND MEDICAL INFORMATION

Diagnosis: Primary: ____

Secondary: ____

Other: ____

How old were you when your disability was initially diagnosed?___________________________

What medications, if any, do you take?____

____

____

Do you need someone to administer medications to you? Yes No

Do you require medication by injection? Yes No
If yes, specify medication ______________________________

Do you have difficulty swallowing medication? Yes No

Do you have seizures? Yes No
What type:________________________________How often______________________
Date of last seizure:______________________Neurologist:______________________

Do you have any other medical conditions, problems or issues that we should know about? Yes No
Please specify: ____

____

____

____

____

Do you have allergies? Yes No Specify:________________________________

____

Do you have any prostheses or invasive devices? Yes No
Specify: ____

____

Primary Physician and/or Health Facility providing Medical Care:

Name: ______________________________ Telephone: ______________________________

Address____

City: ______________________ State: ______________________ Zip: __________________

Date Last Seen:____

Specialist: (if applicable)

Name: ______________________________ Telephone: ______________________________

Address: ____

City: ______________________ State: ______________________ Zip: __________________

Date Last Seen: ____

Additional Specialist: (if applicable)

Name: ______________________________ Telephone: ______________________________

Address:____

City: ______________________ State: ______________________ Zip: __________________

Date Last Seen:____

Dental care provided by:

Name:______________________________ Telephone: ______________________________

Address:____

City:______________________ State: ______________________ Zip: __________________

Have you received Hepatitis B inoculations? Yes No Type:___________

Dates:____________,_____________,_____________ Specify month and year for each.

PERSONAL INFORMATION

Sex:_______ Height:______ Weight:________ Race________ Marital Status:_______

Color of Hair:_________ Color of Eyes:___________ Indentifying Marks:_____________

Language Spoken or Understood:____

Language(s) used at home:____

Sign Language: Fluent: _______ Understand Some:_____________ None:___________

Has legal competence been determined?_________

Do you have a legal guardian?_______If yes, who:_____________________________

Name of Court/Judge:________________________Date of Judgment:_____________

Guardian's Address & Phone:____
____County:______________

FINANCIAL INFORMATION

Please check all sources of financial support that you receive:
____Work income
____Supplemental Security Income (SSI)
____Other Social security Benefits
____Pension Benefits
____Family Support

INSURANCE INFORMATION

Medical Assistance Number (Medicaid):_______________________________________
Medicare Number: ____
Private Insurance Company: ____
Type and Policy Number: ____
Military Benefits or Insurance: ____
Type and Policy Number: ____