



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					
City				State	Zip
Birth Date			Medicaid #		
Email Address			Medicare #		

Applying for:

Life Skills	Work Skills	Number of days Requesting	Days Requesting (please circle) M Tu W Th F
-------------	-------------	---------------------------	--

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

- |   |   |
|---|---|
| <input type="checkbox"/> Supplemental Security Income | <input type="checkbox"/> Social Security Disability Insurance |
| <input type="checkbox"/> Community Mental Health      | <input type="checkbox"/> Vocational Rehabilitation Services   |
| <input type="checkbox"/> Medical Assistance           | <input type="checkbox"/> Other: _____                         |

Check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> I am my own Guardian              | <input type="checkbox"/> We have not filled out guardianship paperwork |
| <input type="checkbox"/> My parents have Power of Attorney |  |
| <input type="checkbox"/> My parents are my Guardian        |  |

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	<i>Requires complete assistance</i>	<i>Needs moderate assistance</i>	<i>Needs some assistance</i>	<i>Needs minimal assistance</i>	<i>Completely independent</i>	?
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? \_\_\_\_\_