

DAY SUPPORT APPLICATION

I. INTRODUCTORY DATA

Participant Name _____

Address _____

Home Phone _____ Work Phone _____ Gender M ___ F ___

Level of Intellectual Disability _____

Other/Secondary Disabilities _____

Primary Language _____ Secondary Language _____

Marital Status _____ Citizenship Status _____

Race _____ Date of Birth _____

Social Security # _____ Medicaid # _____ Medicare# _____

Other Insurance _____ Policy # _____

Social Security Disability Insurance (SSDI) amount _____

Supplemental Security Insurance (SSI) amount _____

Source of Referral _____

Reason for Referral _____

Current/Former Placement and reason for leaving _____

Criminal Justice Status _____

Legal Guardian (Court Appointed) _____

Address _____

Home Phone _____ Work Phone _____

E-mail _____

II. CONTACTS

Family

Father _____ Home Phone _____ Work Phone _____

Address _____

Mother _____ Home Phone _____ Work Phone _____

Address _____

Siblings _____

Residential Placement _____

Residential Contact Person: _____ **Phone:** _____

Other Significant Support Systems _____

Emergency Contacts (please indicate two)

Name _____ Relationship _____

Address _____ Home Phone _____

_____ Work Phone _____

Name _____ Relationship _____

Address _____ Home Phone _____

_____ Work Phone _____

Social Worker/Support Coordinator (Other Agency Involvement)

Name _____ Phone _____

Address _____

Physician

Name _____ Phone _____

Address _____

Dentist

Name _____ Phone _____

Address _____

III. LEVELS OF SUPPORT REQUIRED

Behavioral/Emotional (Include restrictive behavioral strategies, if any)

Communication/Social (Include cultural /religion restrictions, if any)

Medical (Include diagnosis and other medical conditions including restrictions)

Personal Care

Interests/Preferences

Describe any other concerns or issues that may affect participation in day support program:

Day Support Funding Source:

Medicaid ID Waiver _____ Medicaid DD Waiver _____ CSB _____ ICF/MR _____ Other _____

CSB Jurisdiction:

Fairfax-Falls Church _____ Arlington _____ Alexandria _____ Prince William _____ Other _____

CSB Case ID Number: _____

Person Completing Application _____ Date _____

Relationship to Applicant _____

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies and contractors provide different services. Each agency and contractor must have specific information in order to provide services. By signing this form, I am allowing agencies to exchange specific information so it will be easier for them to work together effectively to provide and/or coordinate these services.

I, _____ am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

(FULL PRINTED NAME OF PARTICIPANT)

My relationship to the participant is: Self Legal Guardian Authorized Representative
 Power of Attorney Other

I permit the following information about the participant to be exchanged:

Assessments Medical Other _____
 Financial Psychological _____
 Educational Service Plans _____
 Employment Progress Notes _____

I permit the following agency or contractor to be able to exchange this information:

Community Services Board:

Alexandria Community Services Board
 Arlington Community Services Board
 Fairfax-Falls Church Community Services Board
 Prince William Community Services Board
 Rappahannock Community Services Board

I permit this information to be exchanged for the following purpose(s):

Service Coordination and Treatment Planning
 Eligibility Determination
 Other _____

This consent is good for a year from the day it is signed or if the individual who signed it revokes the consent or his/her competency status changes.

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after my consent has been withdrawn.

I have a right to know what information about the participant has been shared, why, when, and with whom it was shared. If I ask, ServiceSource will show me this information.

I want all the agencies and contractors to accept a copy of this form as a valid consent to share information. If I do not sign this form, information will not be shared and I will have to contact each agency/contractor individually to give them required information about the participant.

Signature(s): _____ Date: _____
(CONSENTING PERSON OR PERSONS)