



L'Arche Blue Ridge Mountains

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APPLICATION FOR SERVICES

Date

I. IDENTIFYING INFORMATION:

Applicants Name: _____ SS#: _____
(Last) (First) (Middle)

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____) _____

Birth Date: __/__/____ Age: ____ Birth Place: _____

Sex: ____ Ht. ____ Wt. ____ Marital Status: _____ Legal Status: _____

Guardianship: Date Adjudicated: __/__/____ Where: _____

Name of Legal Guardian: _____

Type of Guardianship: _____

*Please include a copy of guardianship papers with the application

Emergency Contacts: (Parents, Guardian, etc.)

Name: _____ Relationship: _____

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____) _____ (____) _____
(Home) (Work)

Name: _____ Relationship: _____

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____) _____ (____) _____
(Home) (Work)

I. IDENTIFYING INFORMATION: Emergency Information (cont.)

Name: _____ Relationship: _____

Address: _____
(Street)_____
(City) (State) (Zip) Phone #: (____) (____)
(Home) (Work)

Name: _____ Relationship: _____

Address: _____
(Street)_____
(City) (State) (Zip) Phone #: (____) (____)
(Home) (Work)

*Attach another page with additional information regarding contacts, if you wish.

Responsible Community Services Board: _____

Contact Person/ Case Manager: _____

Telephone Number: (____) _____

*Please include a copy of the applicant's most recent Consumer Service Plan.

II. FINANCIAL INFORMATION:

Medicaid #: _____ Effective Date: ____/____/____

Medicare: Yes____ No____ Claim #: _____

Parts A____ B____

Effective Date: ____/____/____

Social Security Disability Benefits:

(Yes)____ (No)____ Monthly Amount: _____

Claim #: _____ Payee: _____

Supplemental Security Income: (Yes)____ (No)____ Monthly Amount: _____

Payee: _____

Other Type of Insurance? _____

I. FINANCIAL INFORMATION: (cont.)

Other Benefit Type: _____ Claim #: _____

Payee: _____

Additional Source of Income: (Example: Vocational Program, Supported Employment, Etc.):

Prepaid Burial Arrangements: _____

Life Insurance Policy: _____

Which Department of Social Services are you currently utilizing?

Address: _____

Phone #: (____) _____ Contact Person: _____

III. SOCIAL AND DEVELOPMENTAL HISTORY:

Father's Name: _____ Date of Birth: ___/___/_____

Address: _____

(Street)

_____ Phone #: (____) _____ (____) _____

(City) (State) (Zip) (Home) (Work)

Place of Employment: _____

Mother's Name: _____ Date of Birth: ___/___/_____

Address: _____

(Street)

_____ Phone #: (____) _____ (____) _____

(City) (State) (Zip) (Home) (Work)

Place of Employment: _____

III. SOCIAL AND DEVELOPMENTAL HISTORY: (cont.)

Sibling Information:

Name: _____ Date of Birth: ___/___/___

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____) (____)
(Home) (Work)

Name: _____ Date of Birth: ___/___/___

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____) (____)
(Home) (Work)

Name: _____ Date of Birth: ___/___/___

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____) (____)
(Home) (Work)

*Attach another page with additional information regarding siblings, if needed.

Family History: (Please provide information about where you have lived, any significant events in your life, type of relationship you have with family members, participation in community/life organizations, etc.) _____

Developmental History: _____

IV. HISTORY OF EDUCATIONAL SERVICES

Currently receiving educational services? Yes () No () If yes please provide the name and address of the school system. Also attach a copy of the current ISP.

Name of Institution: _____ Contact Person: _____

Address: _____

(Street)

_____ Phone #: (____) _____ (____)

(City) (State) (Zip) (School) (Contact)

Describe previous educational experiences and if you felt your needs were met: _____

Did you receive vocational training? Yes () No () If yes, where: _____

Do you currently work? Yes () No () If yes where:

Place of Employment: _____ Contact Person: _____

Address: _____

(Street)

_____ Phone #: (____) _____ (____)

(City) (State) (Zip) (School) (Contact)

How often do you work? _____

Job Responsibilities: _____

Do you like your job? Yes () No () If no, what else would you like to do? _____

VII. LEVEL OF ASSISTANCE: (cont.)

Type of Diet: _____

Preferred Leisure Activities: _____

VIII. MEDICAL INFORMATION:

Primary Care Physician: _____ Date of last physical exam*: __/__/____

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____)_____

*Include a copy of the most recent medical report and physical examination

Name of Specialist: _____ Type: _____

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____)_____

Name of Specialist: _____ Type: _____

Address: _____
(Street)

(City) (State) (Zip) Phone #: (____)_____

VIII. MEDICAL INFORMATION: (cont.)

Name of Dentist: _____ Date of last exam: ___/___/_____

Address: _____
(Street)

_____ Phone #: (____) _____
(City) (State) (Zip)

Do you require medication prior to a dental examination: Yes () No () If yes please list the name of the medication: _____

Please provide information regarding any past serious illness, infections, diseases, serious injuries, and/or hospitalizations: _____

List known disabilities/ restrictions, equipment, or treatment: (For example: mobility, vision, hearing, nutrition, orthopedic, etc.) _____

Dates of Last Immunizations/ Tests:

Diphtheria: ___/___/_____ Small Pox: ___/___/_____ Chicken Pox: ___/___/_____

Polio: ___/___/_____ TB: ___/___/_____ Influenza: ___/___/_____

MMR: ___/___/_____ Meningitis: ___/___/_____ HIV Screening: ___/___/_____

List any other vaccinations/ screenings not included above: _____

VIII. MEDICAL INFORMATION: (cont.)

Medication	Dose	Purpose	Prescribing Physician	Date of last script

*Attach sheet with additional medications if needed

History of past prescription and over the counter medications and treatments: (Please indicate whether or not the treatments were effective) You may list here or attach a separate sheet:

IX: PSYCHOLOGICAL/ PSYCHIATRIC INFORMATION:

Date of most recent Psychological Evaluation: ___/___/_____

Name of Evaluation: _____

Evaluation Results: _____

Administered By: _____

IX: PSYCHOLOGICAL/ PSYCHIATRIC INFORMATION: (cont.)

Date of most recent ICAP : ___/___/_____

Other Testing: _____

*Please provide copies of evaluations

List diagnosed or treated psychiatric or behavioral conditions past and present: _____

Do you receive services from a Psychiatrist, Licensed Clinical Psychologist or Behavioral Consultant? Yes () No () If so, please provide information below:

Name of Specialist: _____ Type: _____

Address: _____

(Street)

_____ Phone #: (_____) _____

(City)

(State)

(Zip)

If you receive psychotropic medication and it is not listed in the previous medication section please list name and dosages: _____

X. REASON FOR APPLICATION TO L'ARCHE BLUE RIDGE MOUNTAINS

