Independence Association Application of Services

Nondiscrimination notice

Independence Association does not discriminate on the basis of race, color, national origin, or physical or mental handicap in admission or access to, treatment of employment in its programs or activities.

***Note of Importance:** **When filling out this form, please keep in mind that the entire form needs to be completed. It is imperative that we obtain all pertinent information for our records so that this information can be accessed when needed.**

***For additional information please visit our web site at www.independenceassociation.org**

Name of person completing form:_____

Who referred you to our services (or where did you hear of us):_____

APPLICANT INFORMATION:

Name:_____
(Last) (First) (MI)

Address:_____
(Street) (Town) (State) (Zip Code)

Phone #:_____ E-Mail Address:_____ Date of Birth:_____

Disability: Primary_____
Secondary_____ Other Medical Disabilities:_____

GENERAL INFORMATION:

Hair Color:_____ Eye Color:_____ Weight:_____

Height:_____ Sex_____ Distinguishing Marks/Scars:_____

Marital Status:_____

Are you your **"own"** guardian? ☐**Yes** ☐**No**

If no, name of guardian_____Phone:_____

Guardian Address_____
(Street) (Town) (State) (Zip Code)

Are you a consumer of **DHHS**? ☐**Yes** ☐**No**

Caseworker's (ISC) Name:_____Phone:_____

Are you a consumer of **Vocational Rehabilitation**? ☐**Yes** ☐**No**

Counselor's Name:_____Phone:_____

Are you a consumer of **DMH**? ☐**Yes** ☐**No**

Caseworker's Name_____Phone:_____

Do you have a **Community Case Manager?** ☐**Yes** ☐**No**

Community Case Manager's Name:_____Phone:_____

FINANCIAL INFORMATION:

Social Security #_____ Are you your own representative payee? ☐**Yes** ☐**No**

If no, Name of Representative Payee_____Phone_____

Address_____
(Street) (Town) (State) (Zip Code)

_____SSI $_____

_____SSDI $_____

_____AFDC $_____

_____Unemployment, $_____

_____Maine Care,#_____

_____Medicare, #_____

_____Medicare Part "D"

If yes, **Plan Name: _____**

Plan Number: _____

MEDICAL/DISABILITY INFORMATION:

Adaptive equipment/aids used:

_____Glasses/contact lenses _____Wheelchair

_____Hearing aid(s) amplifier _____Augmentative speech devices

_____Braces/ crutches _____Other, specify_____

List any medication(s), and schedule of administration:_____

Can you administer your own medication(s)? ☐**Yes** ☐**No** If yes, for how long?_____

Do you have allergies? ☐**Yes** ☐**No** If yes, specify_____

Significant medical history **(please include major illnesses, surgeries, or accidents)**

Date:_____Specify:_____

Date:_____Specify:_____

Date:_____Specify:_____

Date:_____Specify:_____

Do you have any special travel needs? ☐**Yes** ☐**No** If yes, please specify_____

Do you have any special needs? ☐**Yes** ☐**No** If yes, please specify_____
(E.g. Medical/physical limitations, diet, hearing, sight, physical exertion limitations, etc.)

Physician Information:

Date of last **Physical Exam**:_____Primary Care Physician:_____

PCP Address:_____
(Street) (Town) (State) (Zip code)

Phone:_____

In the event of an emergency, should the Primary Care Physician be contacted? ☐ Yes ☐ No

If no, please indicate PCP to be notified_____
Full Name

Address_____Phone_____

Date of last **Psychological/Psychiatric evaluation**:_____Examiner:_____

Examiner's Address:_____
(Street) (Town) (State) (Zip Code)

Phone:_____

Date of last **Dental Exam**:_____ Dentist:_____

Dentist's address:_____
(Street) (Town) (State) (Zip Code)

Phone:_____

Pharmacy Information:

Name of Pharmacy:_____Phone:_____

Address:_____
(Street) (Town) (State) (Zip Code)

Emergency/Disaster Information:

In the event of an emergency/disaster, who would be the contact person?_____

In an emergency/disaster, please indicate the hospital you wish to provide the treatment:

_____

Name of Hospital Phone

If the individual must be evacuated from their home, or located away from their home during a disaster, the following options may be used: **(Please be as specific as possible)**

First Choice Contact Person:_____Phone:_____

First Choice Location:_____Phone:_____

Additional Evacuation Information:_____
_____
_____

Special Needs: (Please indicate **any** medications, or medical devices this person would need in the event of an emergency/disaster) _____
_____

FAMILY INFORMATION:

Please list any of your significant family members, spouse, correspondents and others, who live with or are involved in your life.

_____

Name Relationship Home Phone

_____

Address Business Phone

E-Mail Address:_____

_____

Name Relationship Home Phone

Address Business Phone

E-Mail Address:_____

Name Relationship Home Phone

Address Business Phone

E-Mail Address:_____

EDUCATIONAL INFORMATION:

What school are or did you attend? _____

Date of last year you attended this school/program:_____ Current grade level_____

Did you receive a **Certificate:**_____ **Diploma**:_____

Academic/functional skills: **(Briefly estimate your skills)**
(E.g. excellent, good, fair, poor)

Writing_____ Personal Care_____

Reading_____ Money Management_____

Independent Living Skills (Cooking, cleaning, etc.)_____

SERVICES INFORMATION:

Reason(s) for applying for services:_____

Will you need assistance arranging transportation? ☐Yes ☐No

If yes, please specify your needs:_____

Please indicate below which service(s) you wish to receive:

Residential Services:

Supported Living_____

Residential_____

Personal Support_____

Day Services:

CommunityWorks_____

Spindleworks_____

Employment_____

EnvisionME____

Children's Services:

Children's In-Home Services_____

Children's Targeted Case Management_____

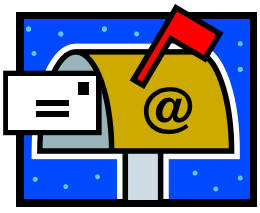
Other Services:

Adult Community Case Management_____

Adult/Children In-Home Supports_____

Learning Center_____

Other, specify____



Please mail or return application to:

Independence Association, Inc.
P.O. Box 642
Brunswick, ME 04011
Attention to:_____

For Office Use Only:

Date application received:_____

Name of person receiving application:_____

Application forwarded to:_____**Date forwarded:**_____