APPLICATION FOR SERVICES

Date of Application: ______________________

Applicant's Full Name: ____

Applicant's Present Address: ____

Applicant's Phone: ______________________ **Birthplace:** ______________________

Birthdate: ______________ **Sex:** ________ **Marital Status:** ____________

Social Security No.: _____ - ____ - _______ **Medicaid No.:** ______________ **Medicare No.:** ____________

Case Manager: ______________________ **County:** ______________________

Case Manager Email: ______________________

___ **Legal Guardian** Name: ______________________ Phone: ______________

Address: ____

Email: ______________________

___ **Co-Guardian** Name: ______________________ Phone: ______________

Address: ____

Email: ______________________

___ **Trustee** Name: ______________________ Phone: ______________

Address: ____

___ **Conservator** Name: ______________________ Phone: ______________

Address: ____

___ **Payee** Name: ______________________ Phone: ______________

Address: ____

Current Primary Caregiver or Provider:

Name: ______________________ Birthplace: ______________________

Address: ______________________ Home Phone: ______________________

______________________ Business Phone: ______________________

Applicant's Parents (if under age 18): Marital Status: M S D W (circle one)

Father's Name: ______________________ Living? _______ Birthdate: ______________

Address: ______________________ Home Phone: ______________________

______________________ Business Phone: ______________________

Birthplace: ______________________ Social Security No.: _____ - ____ - _______

Mother's Name: ______________________ Living? _______ Birthdate: ______________

Address: ______________________ Home Phone: ______________________

______________________ Business Phone: ______________________

Birthplace: ______________________ Social Security No.: _____ - ____ - _______

(Turn over)

APPLICATION FOR SERVICES

SERVICE APPLYING FOR: (please check AMOUNT & TYPE below)

<u>AMOUNT</u>: ☐ Daily ☐ Hourly

<u>TYPE</u>: ☐ ID Waiver ☐ Habilitation ☐ Chapter 24 ☐ Respite ☐ BI Waiver

State why application is being made: (attach supplementary sheet, if necessary)

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Race: _______ **Height:** __________ **Weight:** __________ **Eye Color:** ________ **Hair Color:** _______

Primary Diagnosis: ____

Secondary Diagnosis: ____

Diagnosed Epilepsy? Yes ___ No ___ **Type of Seizures:** ______________________________

Allergies: (record in red ink) ____

Medications: (include dosage)

____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

Does applicant self-administer medication? Yes _______ No ________

Please list any special attention needed for management of bowels, bladder, or any aspect of personal care:

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Rules for acceptance and participation in OHI programs are the same for everyone without regard to race, color, national origin, sex, age, handicap, creed, religion, or political affiliation.