COMMUNITY LIVING, INC.
Application for Services

Date of Application: _____

I. Services applied for:
____ Full Residential Services (ALU)
____ Personal Support Services
____ Individual Family Supports
____ Respite Services
____ Retirement Our Way Program (ROW)
____Vocational/Day Services/Supported Employment

II. Applicant's Name: _____ DOB: _____

Address: _____

City/State/Zip:_____

County: _____

Phone #: _____ Social Security #: __ __ __- __ __- __ __ __ __

MA# (if applicable):_____

III. Name of Parent/ Guardian: _____

Is this person the primary contact? _____ Y _____ N

Address: _____

Phone #: (Home) _____(Work) _____

(mobile) _____

E-mail address:_____

IV. Name of Person Completing form (if different from above): _____

V. Emergency Contact Name and Phone Number (if different than above)

_____

VI. Is the individual his/her own guardian? _____Yes _____No

VII. Does the individual have a: Designated Healthcare Agent _____, Advance Directive _____ (please provide a copy)

VIII. Applicant's Disabilities Identified on most recent evaluations:

_____

_____

IX. Program History

Is applicant presently receiving any DDA services? ___Yes ___No

If Yes: Name of Provider: _____

Type of Service Received: _____

Provider Phone Number: _____

Has the applicant received DDA services in the past?

If Yes: Name of Provider: _____

Type of Service Received: _____

Phone Number: _____

X. Medical/Dental

List any specific health conditions (diabetes, seizures, hearing impairment, etc.)

Condition	Any Treatment required?
_____	_____
_____	_____
_____	_____
_____	_____

Is applicant currently taking any medication? _____Yes _____no

If yes:

Name of Medication	Dose	Purpose of Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician Name and Phone:

_____

List any allergies:_____

_____

Does the individual use any assistive devices: (wheelchair, glasses, communication device)
Please list:

_____

_____

XI. Socialization/Behavior

Does the applicant display any of the following types of behaviors? (If yes, please describe)

Aggression _____Yes _____No

Self-Injury _____Yes _____No

Difficulty sleeping _____Yes _____No

Wandering/Elopement/Darting _____Yes _____No

Eating Inedible Items _____Yes _____No

Destruction of Property _____Yes _____No

Other:

XII. Financial

List resources of applicant income: Check all that apply

1. SSI _____

   Receiving Amount:_____

2. Medical Assistance _____

3. Social Security Disability Income _____

   Receiving Amount:_____

4. VA Benefits _____

   Receiving Amount:_____

5. Section 8 Rental Assistance _____

   Receiving amount:_____

6. Food Stamps_____

   Receiving Amount:_____

7. Medicare _____

8. Other _____ Specify:

XIII. Please describe the individual's most significant interests, likes, preferences, needs (things that will help us support the person in the most meaningful way)

_____

_____

_____

_____

_____

_____

XIV. Attach a copy of the applicant's current Person-Centered Plan if applicable.

XV. If available attach most recent medical, psychological, vocational and other pertinent evaluations.

XVI. Please forward to:

Applications
Community Living, Inc.
620-B Research Court
Frederick, Maryland 21703
(301) 663-8811

Note:

- Community Living requires CLI be assigned as representative payee for all individuals receiving residential services.
- If you receive any services from CLI, you will be asked for a list of physicians or other healthcare providers.

PHOTOGRAPH RELEASE FORM

This letter confirms the agreement between you and Community Living, Inc. identifying you as the legal guardian for someone who participates in Community Living, Inc.'s activities and events in which they may be photographed or videotaped from time to time.
For valuable consideration received, you herby grant Community Living, Inc. perpetually, exclusively, and for all media (social, website, print and digital), the right to incorporate (alone or together with other materials), in whole or in part, photographs or video footage taken as a result of your participation in approved activities of Community Living, Inc. (52-1158064).

AGREED TO AND ACCEPTED

Date_____

DECLINE TO ACCEPT

Date_____

Participants Signature_____

Signature of parent or legal guardian_____

Print name of Participant_____

Print name of Parent or legal guardian_____

Telephone Number_____

E-mail Address _____