INFINITY CARE

APPLICATION FOR SERVICES

Services Requested: Residential (group home, apartment) Community (AFL, personal home) Day Services Employment

Referral Source/Name:	Contact Number:	Application Date:
Referral Address:	E-mail:	

TRANSPORTATION INFORMATION

Check all that apply: Owns scooter/vehicle Rides/Has bicycle Walks Uses public transportation None

PERSONAL IDENTIFICATION OF APPLICANT

First Name:	Middle:	Last:
Address:		
Home MCO:	County:	Social Security #:
Gender:	Date of Birth:	Race:
Phone Number:	Known Allergies:	
Insurance Information (check all that apply)	Medicaid Medicare No Insurance Private Insurance (specify):	

GUARDIAN INFORMATION

Person does not have guardian, N/A (skip this section)

Name:	**Address:**	
Type of Guardianship:	Relationship to Applicant:	Phone Number:
Fax Number:	Email:	Other:

GENERAL HEALTH/MEDICAL INFORMATION

Do you have a primary care physician? Yes No Have you had a physical exam in the past 12 months? Yes No

If yes, name of provider/practice: Please provide as much contact information as you can. Thank you! Address: Phone Number:
Fax Number:

Are you currently experiencing any of the following health problems?

Diabetes Seizures Diarrhea Muscle/joint Problems Other Medical Problems	Yes No Yes No Yes No Yes No Yes No	Heart Problems High Blood Pressure Nausea/Vomiting Change in Appetite	Yes No Yes No Yes No Yes No	Hearing Problems Vision Problems Speech Problems	Yes No Yes No Yes No
		Explain:			

If yes to any above, is person being treated by a healthcare professional for the condition? Yes No ***(Internal: If no, make referral)***

Do you use tobacco? Yes No Are you interested in stopping? Yes No N/A

Medication Name	Dose (mg)?	How often?	Last Use (Date)?	Who Prescribed?	Taken as prescribed
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No

Health Comments:

SELF-CARE INFORMATION

Dining: Independent Minimal Assistance Maximum Assistance Must be fed

Bathing: Independent With Assistance Full Assistance Resistant

Ambulation: Independent Semi-ambulatory Self propels Dependent

Dressing: Independent Verbal cues Physical prompts Full assistance

Communication: Independent Non-verbal Symbol Board Gestures

Toileting: Independent Toilet schedule Incontinent

Sleeping Habits: Sleeps all night Gets up on occasion Trouble sleeping

Self-Care Comments:

FINANCIAL

Able to budget Financially responsible Unable to budget Pattern of reckless spending Financial stress Significant debt Has filed for/declared bankruptcy Stable income Flexible/unstable income No income

FAMILY/SOCIAL SUPPORTS/LIVING SITUATION

Marital Status	Single Married Separated Divorced Widowed Annulled Domestic Partners Unknown	**Number of Children**	

Family/Friend Support	All support Some support No support No family/friends Family/friends don't know
Involvement in faith/religious activity	Attends regularly (strength) Occasional attendance No attendance N/A
Other Areas of Concern	Family desertion Child neglect Child abuse Running away Separation or divorce Custody disputes Domestic violence Conflicts with family/friends Recent death in family/friend

Persons Living in Household (#)		**Describe**	

Current Living Arrangements	Private Residence Homeless Correctional Facility Residential Facility Foster Family/AFL Nursing Home Adult Care Home (7+ beds) Adult Care Home (6 or fewer beds) Other:

Comments:

SOCIAL ROLE/BEHAVIOR

None Isolation worsens symptoms Fabricates truth Destroys property	Limited use of community resources Lacks activity Uncomfortable around others Stealing	Poor impulse control Probation Social isolation Anxiety in relationships	Fighting Promiscuity/Exhibitionism On probation/parole Legal problems

Social Role/Behavior Comments:

EMPLOYMENT/MILITARY/EDUCATION

Current Employment	Full Time Part Time Homemaker Unemployed On disability Retired Student

If yes, where/what type of work?

If no, is person interested in work? Yes No	Current job pays at least minimum wage Person is underemployed

Person/Family Military Service	N/A Active military/national guard Family member in military/natural guard Wounded in combat Operation Enduring Freedom Operation Iraqi Freedom Other Combat (specify):

Currently enrolled If yes, where?

Completed high school/Earned GED Some college Certificate Earned Complete college (degree earned):

Interest in Continuing Education	Yes No	IQ Testing Completed?	Yes No (If yes, request a copy of report)
Please check all that apply:	I have a hard time learning new concepts/ideas.		I have been diagnosed with a learning disability.
	I have or had an IEP (Individualized Education Plan) or 504 Plan.		

TALENTS, INTERESTS & HOBBIES (please list)
Employment/Military/Education Comments:

Legal History I have never been in trouble with the law. (Please skip this section)
I have open/active court cases If so, what are the charges? I am currently scheduled for court If so, when is your court date? I am currently on probation If so, until when? I have spent time in prison/jail If so, when and for how long? I am under legal pressure to attend this program. If so, from whom? If yes, would you be attending the program without this pressure? Yes No Do you think your legal involvement will impact your ability to make progress in treatment? Yes No (please indicate reason in comments)
Prior Convictions (felony or misdemeanor) Number of arrests Most Recent Date
Comments:

PSYCHIATRIC ADVANCE DIRECTIVE		
Does the applicant have a Psychiatric Advance Directive?	Yes No	***If yes, please attach a copy to application.***
If applicant does not have a psychiatric advance directive, would he/she like further information about it?		Yes No

DIAGNOSIS	
Class	**Code/Description**

Please submit completed application along with the following documentation:
Current Person-Centered Plan or Treatment Plan from current service provider
Current Comprehensive Clinical Assessment (If applying for a mental health service or location)
Psychological Evaluation (If applying for a service or location for Intellectual and Developmental Disabilities)
Psychiatric Advance Directive (if applicable)
Documentation of Legal Guardianship (if applicable)
Copy of Medicaid Card (if applicable)
Please submit all information electronically to Referral Coordinator at referrals@infcare.org.