OBI Application for Services

(Please print or type)

Applicant Information:

Name:_____
(Last) (First) (Middle) (Called By)

Current Address:_____
(street)

_____
(City) (State) (Zip Code)

Contact Numbers:_____
(Day) (Home) (Cell)

Email Address:_____

Social Security Number:_____ Date of Birth:_____

Does Applicant have a Legal Guardian? _____Yes _____No

If YES, Name, Address, & Phone # of Legal Guardian:_____

_____

_____

Type of Guardianship (check one that applies):

_____Full _____Property _____Limited _____Medical

Additional Information (completion is not required):

___African American ___Caucasian ___Hispanic ___Native American ___Asian _____Other

Sex: ___Male ___Female U.S. Citizen? ___Yes ___No Marital Status:_____

Language(s) spoken or understood: ____English _____Other (Specify)

Which services are you interested in? Please check all that apply:

Vocational
___Warehouse
___Intermediate
___Job Development Area

Supported Employment
___Job Coaching
___Job Development
___Transportation
___Enclaves

Education
___Computer Classes
___Work Adjustment Training
___Adult Basic Education

Day Habilitation
___ Recreation & Leisure

Other: _____

Caregivers Information:

Name:_____
(Last) (First) (Middle)

Current Address:_____
(street)

_____
(City) (State) (Zip Code)

Contact Numbers:_____
(Day) (Home) (Cell)

Email Address:_____

What's the best way and time to reach you? _____

Applicant Lives With:

Name:_____
(Last) (First) (Middle)

Current Address:_____
(street)

_____
(City) (State) (Zip Code)

Contact Numbers:_____
(Day) (Home) (Cell)

Email Address:_____

Relationship To The Applicant:_____

Family Information:

Parent Information	Father	Mother
Name		
Address		
Home Phone		
Cell Phone		
Preferred Email Address		
Place of Employment		
Position/Title		
Business Phone		
Deceased (yes/no)		
Marital Status		

Sibling Information			
Name			
Address			
Home Phone			
Cell Phone			
Preferred Email Address			
Marital Status			
Place of Employment			
Position/Title			

Emergency Contacts (please list two):

First Contact:

Name:_____
(Last) (First) (Middle)

Current Address:_____
(street)

_____
(City) (State) (Zip Code)

Contact Numbers:_____
(Day) (Home) (Cell)

Email Address:_____

Relationship To The Applicant:_____

Second Contact:

Name:_____
(Last) (First) (Middle)

Current Address:_____
(City) (State) (Zip Code)

Contact Numbers:_____
(Day) (Home) (Cell)

Email Address:_____

Relationship To The Applicant:_____

Financial Information:

Applicant's Medicaid (Medical Assistance) #:_____

Applicant's Medicare #:_____

Other Medical Insurance (Please specify company name and policy #):

_____

_____

Name of Representative Payee (if different from applicant):_____

SSA Amount:_____ SSI Amount_____

Medical Information:

A. Applicant's Primary Health Care Provider/Physician:_____

_____

Address:_____

Phone #: _____ Fax#: _____

Date of Applicant's Last Physical Exam (Copy of Physical Must Accompany Application):_____

Examined by (if different from above):_____

Address:_____

Phone #: _____ Fax#: _____

B. Primary Diagnosis:_____

Secondary Diagnosis:_____

Tertiary Diagnosis:_____

Medical Information Continued:

C. Please list all medication the application is on:

Medication	Dosage	Frequency	Reason

D. Does the Applicant have vision impairment? ____ Yes ____No

Is the Applicant legally blind? ____ Yes ____No

Does the Applicant wear: ____ Glasses ____Reading Glasses ____Contact Lenses

Does the Applicant have a hearing impairment? ____Yes ____No

Does the Applicant wear a hearing aid? ____Yes ____No

Is the Applicant legally deaf? ____ Yes ____No

Date of last hearing evaluation:_____

Comments:_____

_____

E. Does the Applicant have seizures? ____Yes ____No

If yes, please list frequency: _____

_____

Type of seizures:_____

Are seizures controlled by medication? ____Yes ____No

Medical Information Continued:

F. Date of Applicant's last dental examination:_____

Does the Applicant wear dentures? ____Yes ____No

Brief description of any dental problem(s)_____

_____

_____

G. ____Walks Independently ____Uses Cane _____Uses Crutches ____Uses Walker

____Uses Wheelchair Type:_____

Can the wheelchair user: ____Transfer Independently ____Needs Assistance

Can the Applicant cross streets? ___Independently ____With Assistance ____No

Can the Applicant use Mass Transit? ____Independently ____With Assistance ____No

Is the Applicant certified to use Paratransit/MTA Mobility? ____Yes ____No

Does the Applicant have a MTA bus pass? ____Yes ____No Type?_____

H. Does Applicant have any speech/language impairment? ____Yes ____No

Is Applicant verbal? ____Yes ____No

Has Applicant had any speech/language Assessment? ____Yes ____No

Done By:_____

Means of communication: ____Speech ____Sign Language ____Gestures
____Communication Board ____Other

Please explain:_____

_____

Medical Information Continued:

I. List any allergies (bee stings, drugs, dust, mold, food etc.)_____

_____

J. Does Applicant have any other medical conditions not listed above?_____

_____

K. Does Applicant have a history of alcohol or substance abuse? ____ Yes ____No

If Yes, list previous treatment and date:_____

_____

L. Has the Applicant had any significant surgeries or hospitalizations?

_____

M. Does Applicant have a special diet, use adaptive dishes/utensils, or need feeding assistance?

_____

_____

N. Does the Applicant: ____Use the Bathroom independently ____Wear diapers
_____Need transfer assistance to the toilet ____Other (please explain) _____

_____

Psychological Information:

Date of last psychological evaluation (Please provide copy)_____

Applicant's Psychiatrist:_____Phone#:_____

Address:_____

_____

Applicant's Therapist: _____ Phone#:_____

Address:_____

_____

Does Applicant have a history of behavioral problems? ____Yes ____No

If so, describe using the chart below:

Behavior	Frequency	Severity	Intervention

Does the Applicant have a current behavior plan in school? ____Yes ____No

If yes, please explain below (use additional paper if necessary):

_____

_____

Has the Applicant ever been convicted of a crime? ____Yes ____No

If yes, please provide details: _____

_____

_____

Skills

Is Applicant independent in personal self-care skills? ____Yes ____No
(e.g. bathing, dressing, feeding, toileting)

If no, please explain:_____

_____

Can the Applicant self-medicate? ____Yes ____No

Can the Applicant cross streets: ____Independently ____Requires Assistance ____Not Capable

Is the Applicant capable of being home unsupervised? ____Yes ____No

If yes, for how long?_____

Can the Applicant read? ____Yes ____No If yes, what level? _____

Can the Applicant write? ____Yes ____No If yes, what level? _____

What does the Applicant like to do with his/her free time? _____

_____

_____

_____

Employment:

Is the Applicant currently employed? ____Yes ____No

If yes, what is the employer's address?_____

_____

Phone#:_____ Supervisor's Name:_____

Job Title:_____ Start Date:_____ Wage:_____

Duties:_____

Previous Employment, list with most recent first (use additional paper if necessary):

Job #1:

_____

Company Name

_____

Company Street Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

Job #2:

_____

Company Name

_____

Company Street Address

_____

City State Zip

_____

Job Title Supervisor's Name Dates Employed

If the Applicant is not currently employed, what are their job interests?_____

_____

Additional Team Members:

Does the Applicant have a Service Coordinator? ____Yes ____No

If yes, please list name and phone number:_____

_____

Does the Applicant have a current DORS Counselor? ____ Yes ____ No

If yes, please list name and phone number:_____

_____

Does Applicant have a current Social Worker? ____Yes ____No

If yes, please list name and phone number:_____

_____

Signatures:

_____ _____

Signature of Applicant (if over 18 years old) Date

_____ _____

Signature of parent/guardian (if applicable) Date

_____ _____

Signature of Person Completing the form Date