Developmental Disabilities Ministry

APPLICATION FOR SERVICES

HOPETREE FAMILY SERVICES
EST. 1890
HOPETREEFS.ORG

APPLICANT INFORMATION (please print)

Last Name	First	Middle	Preferred Name	Today's Date

Street Address	City	State	Zip Code	County of Residence

Social Security #	Birth Date	Age	Sex	Martial Status (Circle One)
			❑ M ❑ F	Single Married Divorced Separated

Race Weight Height	Religious Affiliation	Name of Church	Approximate date services will be needed:

Type of Service Needed (Check all that apply):	Location Preference (check all that apply):		
❑ Respite Care	❑ Salem	❑ Richmond	❑ Bedford County
❑ In-Home	❑ Abingdon	❑ Fredericksburg	❑ Virginia Beach
❑ Residential Group Home Placement	❑ Martinsville	❑ Farmville	❑ No Preference

Explain Reason Service Is Needed:

Referral Source (Agency or Individual)	Mailing Address/City/State/Zip	Phone Number ( )

Current Living Arrangements:

CONTACT INFORMATION FOR APPLICANT

1. Name of Primary Contact	Home Phone ( )	Cell/Work Phone ( ) ( )	Relationship to Applicant

Address City/State/Zip
Email Address:

2. Contact (if Primary Contact cannot be located)	Home Phone ( )	Cell/Work Phone ( ) ( )	Relationship to Applicant

Address City/State/Zip

3. Contact	Home Phone ( )	Cell/Work Phone ( ) ( )	Relationship to Applicant

Address City/State/Zip

MEDICAL, DENTAL AND PSYCHOLOGICAL INFORMATION

List all current diagnoses:

Primary Care Physician	Address	Phone ( )	Date of Last Visit
Dentist	Address	Phone ( )	Date of Last Visit
Psychiatrist	Address	Phone ( )	Date of Last Visit
Optometrist	Address	Phone ( )	Date of Last Visit

Others (Please list specialty, name, address, phone number and date of last visit for each. Use back of page 1 if necessary):

Please list dates of and reason for any hospitalizations/surgeries:

****Please attach copies of any genetic/psychological testing that indicate a diagnosis of mental retardation/ID****

Current Medications (use reverse side if necessary)

Medication	Dosage	Prescribed By	Reason

Type of Diet: ❑ Regular ❑ Modified ❑ Special Explain modified or special diet:

Allergies (including food) or special medical conditions:

Please Check All That Apply:

Physical Impairments	Special Adaptive Devices	Seizures? ❑ Yes ❑ No Type: ❑ Petite Mal ❑ Grand Mal	Date of Last Seizure
❑ Blind	❑ Wheelchair		
❑ Deaf	☐ Walker	Frequency:	
❑ Knows sign language	❑ Crutches		
❑ Non-verbal	❑ Orthopedic or Special Shoes	Communication needs:	
❑ Semi-ambulatory	❑ Hearing Aid		
❑ Non-ambulatory	❑ Adaptive eating utensils. If yes, please describe.	Please list any behavior problems or concerns. Describe fully and list frequency:	
❑ Cerebral Palsy			
❑ Other (Describe):	☐ Other (Describe):		

ASSESSMENT OF APPLICANT'S SKILLS (Please Check All That Apply)

Type of Skill	Independently	Requires Assistance	Totally Dependent
Walking			
Dressing self			
Toileting			
Feeding self			
Bathing self			
Washing hair			
Brushing teeth			
Telling time			
Making bed			
Shave (male)			
Menses care (female)			
Understanding Numbers (count, add, subtract)			
Handling money			
Use of leisure time			
Cooking meals			

Significant likes of applicant:

Significant dislikes of applicant:

List recreational activities and hobbies applicant enjoys:

Vocational/Educational Training History

List all vocational or educational training and job experience, if any, that the applicant has received. Attach additional sheets if necessary.

	Training/Experience	Agency/Company (Please include address)	Dates
1.			
2.			
3.			

FINANCIAL

Does applicant have a court-appointed legal guardian? ❑ Yes ❑ No	If yes, date entered	If yes, state in which court order was entered

Legal Guardian (Name)	Address
Phone Number ( )	City/State/Zip

****Please attach copy of Court Order with Application****

If there is no court appointed legal guardian, does applicant have an authorized representative with another provider?
❑ Yes ❑ No

If yes, Name	Address
Phone Number ( )	City/State/Zip

How are the applicant's day-to-day financial needs currently being met?

❑ Applicant's own resources ❑ Other Explain:

❑ Family resources

❑ Trust

Have long-term arrangements been made for applicant? ❑ Yes ❑No If yes, explain:

Does applicant receive:	Amount
❑ SSI (Supplementary Security Income)	$ _____
❑ SSDI (Supplemental Security Disability Income)	_____
❑ Social Security	_____
❑ Other _____	_____

If applicant receives Social Security benefits, from whose Social Security benefits does he/she draw?		Name of person responsible for medical:
❑ His/Her own benefits ❑ Parent's benefits		Is this person: ❑ Parent/Guardian ❑ Representative ❑ Other
If receiving benefits from parent, please give Parent's Name	Parent's SS #	

Is applicant eligible to receive:
Medicaid ❑ Yes ❑ No Medicaid #: Medicare ❑ Yes ❑ No Medicare #:

(1) Is applicant covered by a personal health insurance, either individually or with coverage provided under guardian's insurance? ❑ Yes ❑ No		Name/Address of Insurance Company	Name of person taking out policy on applicant
Policy ID #	Group #		

(2) Does applicant have any other insurance benefits (ex. Life, Champus, Railroad Retirement, etc)? ❑ Yes ❑ No		Name/Address of Insurance Company	Name of person taking out policy on applicant
Policy ID#	Group #		

Does applicant have a Living Will? ☐ Yes ☐ No | Does applicant have an Advanced Medical Directive? ☐ Yes ☐ No

Does applicant have a "DO NOT RESUSCITATE" order? ☐ Yes ☐ No

Please provide any burial plans made for applicant:

CURRENT AND PREVIOUS SERVICES RECEIVED

Please list and provide addresses, telephone numbers, Case Managers/Support Coordinator and dates of services, as applicable. Attach additional sheets if necessary.

Community Services Board System:

MR/ID Services:

Mental Health Services:

Social Services:

Department of Rehabilitative Services:

Private Placement Services:

Criminal Justice Status – Has applicant ever been charged with or been convicted of any violation of the law?

❑ Yes ❑ No If yes, please provide details:

_____ _____

Person Completing Application Date

Relationship to Applicant _____

Send completed application to:

ATTN: MENDY FLYNN
HOPETREE FAMILY SERVICES
DEVELOPMENTAL DISABILITIES MINISTRY
POST OFFICE BOX 849, SALEM, VA 24153
OR FAX TO: (540) 444-4681