HARTWOOD FOUNDATION, INC.
3702 Pender Drive * Suite 410 * Fairfax, VA 22030
703-273-0939 (phone) * 703-273-6807 (fax)

We're opening a lot of doors

APPLICATION FOR SERVICES

A. Processing Information (this section to be filled out by HFI staff)

	DATE	INITIALS
1. Referral Letter Received	_____	_____
2. Application Received	_____	_____
3. Follow-Up Contact	_____	_____
4. Intake Meeting	_____	_____
5. Intake Decision	_____	_____
6. Date of Admission	_____	_____
B. General Information of Service Applicant	_____	_____

1. Applicant's Name_____

2. Present Address _____

3. Permanent Address_____

Service(s) applying for:

☐ Group home (24 hour staff support)

☐ Supported Living - Group home

(Generally 8.0 hours staff support daily)

☐ In-Home Supports

☐ Emerg. Residential Respite (Facility-based)

☐ Private Respite (Facility-based)

☐ Respite Subsidy Program

4. Home Telephone _____ 5. Day Telephone _____

6. Date and Place of Birth: _____ 7. Gender: ☐ Male ☐ Female

8. Social Security Number_____ 9. Citizenship Status* _____

10. Marital Status_____ 11. Legal Status _____

12. Language spoken and/or understood _____

13. Religious Preference* _____

* Provision of this information is voluntary. HFI does not discriminate against applicants because of race, sex, creed, religious or national origin.

14. Medical Insurance (company/policy number) or Medical Assistance

(type/number) _____ (type/number) _____

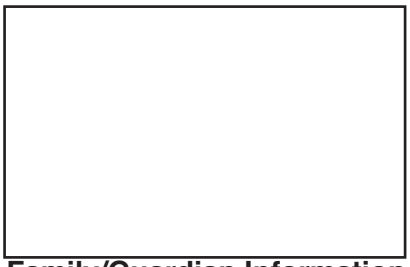
(type/number) _____ (type/number) _____

C. Identification Information

1. Height _____2. Weight _____ 3. Eye Color _____

4. Hair Color_____5. Identifying Marks _____

6. Recent Photograph (please attach)



D. Family/Guardian Information

1. Parent(s) Name(s) or Next-of-kin (if parents are deceased)

a. Name _____

b. Address_____

c. Telephone Number _____

d. Nature of Relationship _____

2. Sibling Information:

Name	Age	Gender	Address

E. Emergency/Other Contacts

1. Physician
    a. Name _____
    b. Address _____
    c. Telephone Number
2. Pastor/Priest/Rabbi (Provision of this information is voluntary. HFI does not discriminate against applicants because of race, sex, creed, religious or national origin.)
    a. Name _____
    b. Address _____
    c. Telephone Number _____
3. CSB Support Coordinator (if assigned): Phone number:

F. Program Information

1. Employment / Day Support Background (List present or last place of employment or day support). Attach separate page for previous employment.)
    a. Current Employer / Day Service Provider: _____
    b. Address _____
    c. Supervisor _____
    d. Phone Number _____
    e. Dates of employment/service _____
2. Educational Background (list present or last attended school. Attach separate page for other schooling).
    a. School _____
    b. Address _____
    c. Phone Number _____
    d. Diploma/highest grade completed _____
    e. Concentration/specialized study
    f. Dates of attendance

3. Vocational/Other Training Background (list present or last training program. Attach separate page for previous training).

   a. Place _____

   b. Address _____

   c. Phone number _____

   d. Supervisor/Counselor _____

   e. Area(s) of Training _____

   f. Date(s) of Training _____

4. Residential Program Background (if applicable, list additional information on separate page).

   a. Program _____

   b. Business address

   c. Phone number _____

   d. Supervisor/Counselor _____

   e. Dates of Residence _____

G. Individual Support Information

1. Medical, Behavioral and Social condition(s) resulting in need for support;

   a. Name(s)/Diagnoses: _____

   _____

   b. Nature of diagnose(s)

      1) General Capabilities _____

      _____

      _____

      2) Major Limitations/Restrictions to daily activities: _____

      _____

      _____

      3) Use of adaptive devices /equipment (wheelchair, walker, etc.): _____

      _____

      _____

2. Medical Status/History

a. Description of general health _____

_____

_____

b. Last Physical (physician/date) _____

1) Current medications (prescription and nonprescription, type, dosage, frequency, condition being treated, method of administration, Note “None” if appropriate)

_____

_____

_____

_____

_____

_____

c. Allergies (note “None” if appropriate) _____

_____

_____

d. Recent physical complaints _____

_____

_____

e. Serious illnesses and chronic conditions of applicant’s parents and siblings, if known _____

_____

_____

f. Past serious illnesses, infectious diseases, serious injuries and hospitalizations _____

_____

_____

g. Substance abuse history, if applicable _____

_____

_____

3. Drug Use Profile

a. List of prescription and nonprescription drugs taken during the past 6 months (if not listed above)

_____

b. List any drug allergies, idiosyncratic or adverse drug reactions

_____

_____

_____

c. List any past ineffective medication therapy

_____

_____

_____

4. Sexual Health and Reproductive History

a. List and describe any past/present sexual health issues

_____

_____

b. Does the service applicant have any children? ☐ Yes ☐ No

If yes, List name(s), age(s), address(es) and contact frequency and issues:

_____

_____

_____

5. Independent/Personal Living Skills

a. Self-help (grooming, dressing, bathing, feeding, toileting)

_____

_____

_____

b. Communication (strengths and support needs)

_____

_____

_____

c. Household (cleaning, cooking, laundry)

_____

_____

_____

d. Leisure (interests, activities, hobbies)

_____

_____

_____

e. Mobility (if you use cane, walker, or wheelchair, please note)

_____

_____

_____

f. Behavioral (list strengths and support needs)

_____

_____

_____

g. Community (shopping, banking, use of public transportation)

_____

_____

_____

H. Financial Information

1. Representative Payee for Benefits: _____
2. Income/Assets
   a. Salary $_____ per _____
   b. Training wages $_____ per _____
   c. Savings (amount) $_____
   d. Other assets (please specify nature and value) _____

_____

_____

_____

3. Government Benefits / Financial assistance (if applicable, fill in monthly amount)
   a. SSI: _____
   b. SSDI: _____
   c. Medicaid:_____
   d. Medicare: _____
   e. Food Stamps: _____
   f. Other (please specify) _____

I. Personal Information

1. Why do you want/need to receive services? Specify exact needs.

_____

_____

_____

2. How soon do you need services? (If immediately, please specify a reason).

_____

_____

_____

3. When, where, and how would you like us to contact you?

_____

_____

_____

*** FOLLOWING 4 QUESTIONS FOR RESPITE SUBSIDY PROGRAM APPLICANTS ONLY:**

1. Preferred Location of respite services: ☐ family home ☐ provider home ☐ either
2. General Days and times/time frames that services are needed:_____
3. Would you like a copy of Hartwood's "Interested Provider" list? ☐ Yes ☐ No
   (If yes, release form must be completed prior to provision of list)
4. Would the provider(s) be responsible for administering medications? ☐ Yes ☐ No

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature and title/position of Person(s) filling out application (if not applicant) Date