



## **Application For Services**

Dear Applicant,

Please take the time to complete this application in its entirety, in order to be considered for services. It is very important that we obtain clear and accurate information regarding your situation. If you are filling out this application for someone else, please be sure to sign your own name as the preparer and allow the applicant to sign as them self. This application must be submitted in conjunction with a letter of recommendation or need from your medical professional or residential service facility administrator. We will not be able to process this application without a letter of recommendation or need for services. If you need more space to answer any of our questions, please feel free to attach additional sheets. Thank you!

### **Personal**

Full Name:

---

Sex: M or F DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Current Residential Service Facility, Address, and Phone Number:

---

---

---

---

Applicant's Direct Phone Number: \_\_\_\_\_

Length of Time in Current Placement: \_\_\_\_\_





**Family Involvement**

Family Members:

Active? Y or N	Name & Relation

What kind of help do you receive from your family currently?

---

---

---

---

How frequently do you receive family support currently?

---

Are you a family member seeking assistance that currently covers the cost of your loved one in a residential placement?   Y   or   N

**Health Information**

List your insurance providers and policy numbers; you can also attach card copies if preferred:

---

---

---

---



Are you currently being treated for any long term illnesses?

---

---

---

---

Are you ambulatory? Y or N

Can you leave your residential service environment for community outings or etc. ? Y or N

Do you require dental care not covered by your insurance? Y or N

Do you currently require psychiatric care that is not covered by your insurance, or provided by your current residential environment? Y or N

How would you describe your overall health?

---

---

---

---

How could your current health situation be improved, if at all, in your opinion?

---

---

---

---

Do you have outstanding medical or dental bills currently? Y or N





Do you feel like your income currently meets all of your needs? Why or why not?

---

---

---

---

The above application has been completely, honestly, thoroughly, and completely to the best of my knowledge and/or ability.

**Prepared By:** \_\_\_\_\_  
Name Signature Date

**Applicant:** \_\_\_\_\_  
Name Signature Date

Don't forget your *Recommendation For Services* form!

**What We Do With Your Information:**

Holding Hands Community Services compiles client data to categorize the priority of each request. Knowing your unique situation helps to coordinate the services you need, and analyze how to implement them most promptly. Several insurance companies have services that are available to their policy holders that have to be applied for specifically. Likewise some communities have services that are available only upon request. We are happy to advocate for the services you need by any means available. By methodically compiling a complete vision of you as an individual and your resources, we can systematically approach every opportunity available to you, i.e. Medicaid waivers even - if you are not on Medicaid, special groups to which you belong that provide additional assistance, grants, and other services apart from the assistance we can provide as an organization. Your information is held in the strictest confidentiality, and will never be shared without your consent.