

IDENTIFYING INFORMATION

Applicant's Full Name: _____
(First) (Middle) (Maiden) (Last)

Current Address: _____
(Street) (City) (County) (State) (Zip)

Permanent Address: _____
(Street) (City) (County) (State) (Zip)

Email Address: _____ **Social Security Number:** _____

Telephone Number: _____ **Birth Date:** _____ **Sex:** Female Male

Birthplace: _____
(Name) (County) (State) (Zip) (Country)

Applicant's Marital Status: Single Married Divorced Separated Widowed

Applicant has a driver's license or ID card: Yes No
State of Issue: _____ **License #:** _____ **Expiration Date:** _____

Citizenship Status: _____

Father's Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Employer:** _____

Current Marital Status: _____ Deceased

Mother's Name: _____
(First) (Middle) (Last) (Maiden)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Employer:** _____

Current Marital Status: _____ Deceased

GUARDIANSHIP / CONSERVATORSHIP

Applicant's status as a protected person:

- A minor Independent adult
 Has a legally appointed guardian Has a conservator

Guardian/Conservator Name (if other than parent): _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____

Date Guardianship Established: _____ **Type:** Full Limited

***Please attach a copy of guardianship / conservatorship papers**

REQUESTED SERVICES (check all that apply):

___ Employment Services

Requested Start Date: _____
 Vocational Training Community Employment Volunteering N/A

___ Day Services

Requested Start Date: _____
 Vocational Training Custodial Food Service N/A
 Alternative Services Enclave Volunteering

___ Medical Services / Therapies

Requested Start Date: _____
 Nursing Services Speech & Language N/A
 Physical Therapy Occupational Therapy

___ Residential Services

Requested Start Date: _____
 Supported Living Home with 24 hour support N/A
 Supervised Apartment / Home

Residential Goals: To live with family To buy a house or condominium To rent own home or apartment
 To live alone To have a roommate 24 hr. support needed

DEVELOPMENTAL DIAGNOSIS

Please indicate doctor's diagnosis (check all that apply)*:

*Documentation required

- | | |
|--|--|
| <input type="checkbox"/> Cognitive Delay / Learning Disability | <input type="checkbox"/> Autism |
| IQ: <input type="checkbox"/> Borderline (71-85) | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Mild (52-70) | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Moderate (36-51) | <input type="checkbox"/> Epilepsy/Seizure Disorder |
| <input type="checkbox"/> Severe (20-35) | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Profound (20 or below) | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> No Cognitive Delay | |
| <input type="checkbox"/> Other _____ | |

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Blind | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Deaf |
| <input type="checkbox"/> ADHD or ADD | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Asthma / Lung Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Heart Defect | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rubella Syndrome |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Prader Willi Syndrome | <input type="checkbox"/> Ulcers / Stomach Problems | <input type="checkbox"/> Stroke (Post CVA) |
| <input type="checkbox"/> Tourette's Syndrome | | | |

Other: _____

Were any of these conditions diagnosed after age 22? Yes No

If yes, which ones? _____

ADAPTIVE EQUIPMENT

Check any of the corrective devices or adaptive equipment applicant uses:

- | | | | | |
|--|--|--------------------------------------|---|--|
| <input type="checkbox"/> eyeglasses | <input type="checkbox"/> corrective lenses | <input type="checkbox"/> AFO's | <input type="checkbox"/> orthopedic splints | <input type="checkbox"/> orthopedic shoes/braces |
| <input type="checkbox"/> dental braces | <input type="checkbox"/> dentures | <input type="checkbox"/> body jacket | <input type="checkbox"/> gait belt | <input type="checkbox"/> helmet |
| <input type="checkbox"/> catheter | <input type="checkbox"/> colostomy bag | <input type="checkbox"/> hearing aid | <input type="checkbox"/> manual wheelchair | <input type="checkbox"/> electric wheelchair |
| <input type="checkbox"/> walker / cane | <input type="checkbox"/> crutches | <input type="checkbox"/> bed rails | <input type="checkbox"/> shower chair | <input type="checkbox"/> mechanical lift |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> Other (please specify): _____ | | | |

MEDICAL INFORMATION

Primary Care Physician: _____

Clinic: _____

Address: _____

(Street)

(City)

(State)

(Zip)

Date of last visit: _____ Phone: _____

COMMUNICATION

Primary means of expression:

Speaks Sign Language Gestures Communication Device

Other (please specify): _____ Describe: _____

What language does applicant speak and/or understand? _____

Please check the items that apply, and describe the applicant, as objectively as possible. This information is needed to plan for the applicant's best interests while being served by South Dakota Achieve.

Yes No Intentionally hurts self
Please describe: _____

Yes No Physically aggressive towards others
Please describe: _____

Yes No Disruptive (such as frequent tantrums, screaming, other emotional outbursts)
Please describe: _____

Yes No Potentially dangerous to others or self
Please describe: _____

Yes No Takes others possessions
Please describe: _____

Yes No Any other concerns such as verbal or physical threats, difficulty relating to peers/authority, etc.
Please describe: _____

EDUCATION

Applicant is currently in school Yes No Name of School: _____

Last Grade Attended: _____ Years: _____

Applicant has a signed diploma Yes No

Applicant has a GED Yes No

EMPLOYMENT

Current Employer: _____ Type of Work: _____

Address: _____ Supervisor: _____

Reason for Leaving: _____ Dates: _____

Past Employer: _____ Type of Work: _____

Address: _____ Supervisor: _____

Reason for Leaving: _____ Dates: _____

FINANCIAL INFORMATION

Financial Institution / Bank: _____

(Street) (City) (State) (Zip)

Yes No Applicant has a Savings account Amount in Savings: _____
 Yes No Applicant has a Checking account Amount in Checking: _____

To assist in determining applicant's eligibility for services, please list sources and amounts of income (check all that apply):

Social Security Amount: _____
 Supplemental Security Income (SSI) Amount: _____
 Veteran's Administration Amount: _____

Who is Representative Payee? _____

(Name) (Street) (City)

(State) (Zip) (Phone)

(email)

Applicant does not currently receive benefits, but has applied
 Date applied: _____ Benefit Type: _____ Result: _____

Any other sources of Income: Yes No
 (e.g.: joint bank accounts, Indian Land Lease, trusts, stocks, bonds, annuities, CDs, Child Support, AFDC, wages, interest, property owned, BIA, railroad, etc.):

Describe: _____
 Amount(s): _____

List all Life Insurance policies that applicant owns or may make payment to applicant as a beneficiary:

(Company) (Address) (Policy Number) (Annual Premium)

Medicaid Number: _____
Medicare Number: _____ Part A Part B Both Part A and B

Enrolled in Medicare Part D: Yes No
 Medicare D Card available: Yes No

List all Health Insurance policies (except Medicare or Medicaid) which include coverage and may make payments for physicians services, hospitalization, nursing home care or drugs and policies that may make cash payments during any spell of illness:

(Company) (Address) (Policy Number) (Annual Premium)

Applicant has money in an account / on deposit with a funeral home / for the purpose of paying for a funeral:

Yes No Where: _____ What Amount: _____
 Yes No Interest is paid to applicant on this account
 Yes No Applicant has specific burial instructions (explain): _____

PLANNING INFORMATION

By answering the following questions, applicant will not jeopardize his/her acceptance to Achieve. This information is used to assist Achieve staff in planning for the best environmental supports and services which may be required to meet an applicant's needs.

Has applicant ever been arrested?

Yes

No

Why: _____

Jurisdiction: City: _____ State: _____ Federal: _____

Disposition of the Charge: _____

Has applicant had any other involvement with the police / court / judicial system?

Yes

No

If yes, please explain: _____

Print Applicant's Full Name

DATE

SIGNATURE

Documentation to enclose with this application (if applicable):

Current IEP / Past Provider Records

Diagnosis Documentation

Guardianship Document

Copy of certified birth certificate

Copy of Social Security Card

Copy of state-issued photo ID

Copy of Medicaid / Medicare Cards

Current ICAP and Summary Pages

Adult Psychological Evaluation

Copy of Tribal Documentation

Citizenship Documentation

Referral Source:

(Name)

(Agency)

(Address)

(City)

(State)

(Zip)

(Phone)

(email)

EMERGENCY CONTACT (if parent or guardian cannot be reached):

(Name)

(Relationship to Applicant)

(Address)

(City)

(State)

(Zip)

(Home Phone)

(Work Phone)

(Cell Phone)

(email)

(Employer / Occupation)

Please continue on next page...

OTHERS WHO ASSISTED WITH COMPLETION OF THIS APPLICATION:**Name:****Relationship to Applicant:**

APPLICANT SIGNATURE:**PARENT/GUARDIAN SIGNATURE:****DATE:****DO NOT WRITE IN THIS SPACE**

Date Application Received:

Admissions Director Signature: