Independence Association
Celebrating Ability Since 1966

Application of Services

Date application provided: _____

Nondiscrimination notice

Independence Association does not discriminate on the basis of race, color, national origin, or physical or mental handicap in admission or access to, treatment of employment in its programs or activities.

***Note of Importance:** **When filling out this form, please keep in mind that the entire form needs to be completed. It is imperative that we obtain all pertinent information for our records so that this information can be accessed when needed.**

***For additional information please visit our web site at www.independenceassociation.org**

Name of person completing form: _____

Who referred you to our services (or where did you hear of us):_____

APPLICANT INFORMATION:

Name:_____
(Last) (First) (MI)

Physical Address:_____
(Street) (Town) (State) (Zip Code)

Mailing Address:_____
(if different) (Street) (Town) (State) (Zip Code)

Date of Birth:_____ Phone #:_____ E-Mail Address: _____

Disability: Primary_____

Secondary_____ Other Medical Disabilities:_____

GENERAL INFORMATION:

Hair Color:_____ Eye Color:_____ Weight:_____

Height:_____ Sex:_____ Distinguishing Marks/Scars:_____

Marital Status:_____

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Are you your **"own"** guardian? ☐**Yes** ☐**No**
If no, name of guardian_____Phone:_____

Guardian Physical Address_____
(Street) (Town) (State) (Zip Code)

Guardian Mailing Address_____
(if different) (Street) (Town) (State) (Zip Code)

Guardian E-Mail Address _____

Are you a consumer of **Vocational Rehabilitation**? ☐**Yes** ☐**No**

VR Counselor's Name:_____Phone:_____

Do you have a **Community Case Manager?** ☐**Yes** ☐**No**

Community Case Manager's Name: _____

Agency name and Address:_____

Phone: _____ Email Address: _____

Funding source: Maine Care section 21 Waiver_____ Maine Care Section 29 Waiver _____

Please list other planning team members who you would like Independence Association to collaborate with for service and treatment needs below:

Contact Name:	**Relationship/ Organization:**	**Address:**	**Telephone Number:**	**E-mail address**

FINANCIAL INFORMATION:

Social Security #_____ Are you your own representative payee? ☐**Yes** ☐**No**

If no, Name of Representative Payee_____Phone_____

Address_____

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(Street) (Town) (State) (Zip Code)

_____SSI $_____ _____Maine Care,#_____

_____SSDI $_____ _____Medicare, #_____

_____AFDC $_____ _____Unemployment, $_____

_____Medicare Part "D" If yes, **Plan Name:** _____ **Plan Number:** _____

MEDICAL/DISABILITY INFORMATION:

Adaptive equipment/aids used:

_____Glasses/contact lenses _____Wheelchair

_____Hearing aid(s) amplifier _____Augmentative speech devices

_____Braces/ crutches _____Other, specify_____

List any medication(s), and schedule of administration:_____

_____

_____

_____

Can you administer your own medication(s)? ☐**Yes** ☐**No** If yes, for how long?_____

Do you have an infectious disease or have you been exposed to an communicable disease in the last 90 days that we should be aware of when planning program tours, visits or new placement? (such as; coronavirus, influenzas, c-diff/clostridioides difficile) ☐**Yes** ☐**No** If yes, please specify_____

Do you have allergies? ☐**Yes** ☐**No** If yes, specify_____

Significant medical history **(please include major illnesses, surgeries, or accidents)**

Date:_____Specify:_____

Date:_____Specify:_____

Date:_____Specify:_____

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Do you have any special travel needs? ☐**Yes** ☐**No** If yes, please specify_____
_____
_____

Do you have any special medical needs that we can help you with? ☐**Yes** ☐**No** **(E.g. Medical/physical limitations, diet, hearing, sight, physical exertion limitations, etc.)**

If yes, please specify_____
_____
_____
_____

Do you have any behavioral health needs that we can support you with? (**E.g, positive behavior support plan, safety plan, emotional support needs etc)** ☐**Yes** ☐**No**

If yes, please specify_____
_____
_____
_____

Physician Information:

Date of last **Physical Exam**:_____Primary Care Physician:_____

PCP Address:_____
(Street) (Town) (State) (Zip code)
Phone:_____

In the event of an emergency, should the Primary Care Physician be contacted? ☐ Yes ☐No

If no, please indicate PCP to be notified_____
Full Name

Address_____Phone_____

Date of last **Psychological/Psychiatric evaluation**:_____Examiner:_____

Examiner's Address:_____
(Street) (Town) (State) (Zip Code)

Phone:_____

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Date of last **Dental Exam**:_____ Dentist:_____

Dentist's address:_____
(Street) (Town) (State) (Zip Code)

Phone: _____

Pharmacy Information:

Name of Pharmacy: _____ Phone:_____

Address: _____
(Street) (Town) (State) (Zip Code)

Emergency or Disaster Information:

In the event of an emergency/disaster, who would be the contact person?_____

In an emergency/disaster, please indicate the hospital you wish to provide the treatment:

_____
Name of Hospital Phone

If the individual must be evacuated from their home, or located away from their home during a disaster, the following options may be used: **(Please be as specific as possible)**

First Choice Contact Person: _____Phone: _____

First Choice Location: _____Phone:_____

Additional Evacuation Information: _____
_____
_____

Special Needs: (Please indicate **any** medications, or medical devices this person would need in the event of an emergency/disaster) _____
_____
_____

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FAMILY INFORMATION:

Please list any of your significant family members, spouse, correspondents and others, who live with or are involved in your life.

Name Relationship Home Phone

Address Business Phone

E-Mail Address:_____

Name Relationship Home Phone

Address Business Phone

E-Mail Address:_____

Name Relationship Home Phone

Address Business Phone

E-Mail Address:_____

EDUCATIONAL INFORMATION:

What school did you attend? _____

Date of last year you attended this school/program: _____ Current grade level_____

Did you receive a **Certificate:**_____ **Diploma**:_____

Academic/functional skills: **(Briefly estimate your skills)**
(E.g. excellent, good, fair, poor)

Writing_____ Personal Care_____

Reading_____ Money Management_____

Independent Living Skills (Cooking, cleaning, etc.)_____

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SERVICES INFORMATION:

Reason(s) for applying for services:_____

_____

Will you need assistance arranging transportation? ☐Yes ☐No

If yes, please specify your needs:_____

Is there other information that you think would be helpful for us to know when you are applying for services with Independence Association?

_____

_____

_____

Please indicate below which service(s) you wish to receive:

Residential Services:

Community Living
(supported apartment & In Home Support) _____

Residential_____

Shared Living_____

Community Services:

CommunityWorks & EnvisionME_____

Spindleworks_____

SpinOff Studio_____

Case Management Services:

Adult Community Case Management_____ Children's Targeted Case Management_____

Please include the following documents with your application to ensure timely referral and intake:

- Most recent physical examination
- Physicians health record for diagnosis and/or recovery of communicable disease (if applicable)
- Most recent diagnostic evaluation
    - (Evaluation should support eligibility as a person with Intellectual Disabilities or Autism)
- Proof of guardianship if applicable

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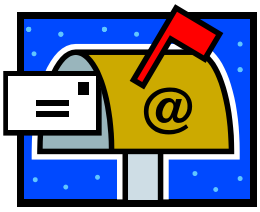

Please mail or return application to:
Independence Association, Inc.
3 Industrial Parkway
Brunswick, ME 04011
Attention: Central Intake

For Office Use Only:

Date application received:_____

Name of person receiving application:_____

Application forwarded to:_____**Date forwarded:**_____