bello machre
Enriching Lives Heart by Heart™

Community Services Application

Services Interest (Please select all that apply)

- ☐ Community Development Services
- ☐ Employment Services
- ☐ Residential Services

Applicant's Information

Full Name:	Application Date:
Home Address:	Home Phone: Work Phone: Cell Phone: Email Address:
Date of Birth:	Social Security #:
Service Coordinator: CCS Mobile #: Email Address:	Medical Assistance #: Medicare #: Other Insurance #:
Guardianship Status: * The individual is automatically their own guardian unless official court documents exist within the individual's File.	
Current Funding Source: DDA /	HRST Matrix Score:
Current Program Services: Address:	Program Director: Program Manager: Other: Work Phone: Email Address:

Alone Time:

(As agreed, upon by the team during the PCP / IEP)	**Please answer Yes or No**
	Can dial 911 during an emergency:
Home Alone Time:	Can self-evacuate during an emergency:
	Can regulate own water temperature:
Community Alone Time:	Has an Advanced Directive:

Emergency Contacts

1st Emergency Contact:	Home Phone:
Relationship: Name: Address:	Work Phone: Cell Phone: Email Address:
2nd Emergency Contact	Home Phone:
Relationship: Name: Address:	Work Phone: Cell Phone: Email Address:
3rd Emergency Contact	Home Phone:

Relationship: Name: Address:	Work Phone: Cell Phone: Email Address:

Please list all diagnoses:
Please list all allergies: (Food, medications, environmental, etc.)
*** Do you require the use of an Epi-Pen? Yes: ◯ No: ◯ Allergy:**
Please list all dietary requirements: (Food / Liquid Consistency / Fluid Restrictions, etc.)
Please list all assistance required with Activities of Daily Living: (Toileting, feeding, dressing, bathing, etc.)
Please list all specialized equipment required: (Wheelchair, Walker, Hoyer Lift, etc.)

Physician Information

Primary Care Physician (PCP) Name: Address:	Office Phone: Office Fax:
Dentist Name: Address:	Office Phone: Office Fax:

Medication List: (Please list all routine, OTC, and PRN medications)

Medication Name	Dosage	Prescribed for What Condition:	Times Given
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

***Are you able to self-medicate? Yes: ◯ No: ◯**

Have you had any significant surgeries or hospitalizations? Yes: ◯ No: ◯ If yes, please explain…
Do you have any chronic conditions that require frequent visits to the ER or hospitalizations? Yes: ◯ No: ◯
If yes, please explain…

Communication

Please list all methods that you utilize to communicate: Speech, Sign Language, Communication Device, etc.)
What is your primary language?
If verbal, do you have a speech or language impairment? Yes: ◯ No: ◯
If deaf or hearing impaired, do you utilize a hearing aid? Yes: ◯ No: ◯ Which ear?
Can you read? Yes: ◯ No: ◯ If yes, what grade level?
Can you write? Yes: ◯ No: ◯ If yes, what grade level?

Education

Level of Education	Name of School City & State	Did you Graduate?	Certificate / Diploma or Degree Earned
High School			
Vocational / Technical			
College (Undergraduate)			

Employment / Internship / Volunteer Experience

Employer:	Dates Employed: From To
Address:	Salary / Hourly Rate:
	Responsibilities:
Phone Number:	
Job Title:	
Supervisor Name:	
Employer:	Dates Employed: From To
Address:	Salary / Hourly Rate:
	Responsibilities:
Phone Number:	
Job Title:	
Supervisor Name:	
Employer:	Dates Employed: From To
Address:	Salary / Hourly Rate:
	Responsibilities:
Phone Number:	
Job Title:	
Supervisor Name:	
Employer:	Dates Employed: From To
Address:	Salary / Hourly Rate:
	Responsibilities:
Phone Number:	
Job Title:	
Supervisor Name:	

Please begin with your most recent position and list all employment, intern, or volunteer experience.

Supported Employment Questionnaire

Are you legally eligible to work in the United States? Yes ____ No ____ (US Citizen, Naturalized Citizen, Work Permit Visa, etc.) ** Upon hire, you will need to submit a W4, MD 507, and I-9 Form to determine legal eligibility and tax status.*

Do you currently have a job? Yes:____ No:____ If yes, where?

_____

Supervisor Name: _____ Phone Number:

_____

Work Schedule: M ____ T ____ W ____ Th ____ F ____ Sat ____ Sun ____

If you are not currently working, are you interested in obtaining competitive employment in the near future?

(Job for pay): Yes:____ No:____ Prefer to work: Full-time _____ Part-time _____

What days are you available to work: M T W Th F Sat Sun *(please circle all that apply)*

Do you have reliable daily transportation to and from work? Yes: No:

If you do not have reliable transportation, are you willing to learn to utilize public transportation options such as: MTA Bus, Metro Train, Mobility, Taxi Cabs, Uber, etc.? Yes: No:

Do you have a current DORS Counselor? Yes: No: Name:

Hobbies and Interests (Please check all that apply)

_____ Animals	_____ Exercising at the Gym	_____ Playing/Watching Sports
_____ Shopping	_____ Watching TV/Movies	_____ Playing/Listening to Music
_____ Arts & Crafts	_____ Gardening/Landscaping	_____ Indoor Recreational Activities
_____ Games/Puzzles	_____ Taking Classes/Courses	_____ Outdoor Recreational Activities
_____ Cooking/Baking	_____ Spending Time in Nature	_____ Reading/Listening to Audio Books
_____ Aquatics (Swimming)	_____ Computer/Video Games	_____ Visiting Museums/Points of Interest

_____ Other: _____

_____ Other: _____

Skills and Talents (Please tell us about any specific skills or talents that you already possess).

What do you enjoy doing in your free time? (Please provide as much detail as possible).
