|  |  |
| --- | --- |
|  | Dream Connections Inc. |

# Program Application

## Applicant Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date of Birth: |  |
|  | Last | First | M.I. |  |  |

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Desired Start Date: |  | Social Security No.: |  | Medicaid# and County : |  |

|  |  |
| --- | --- |
| Program Applied for: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you attended any type of day program in the past? | YES[ ]  | NO[ ]  | Allergies?  | YES[ ]  | NO[ ]  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have a legal guardian? | YES[ ]  | NO[ ]  | If yes, Name & Number  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Are you currently involved in any legal matters? | YES[ ]  | NO[ ]  |  |

|  |  |
| --- | --- |
| If yes, explain: |  |

## Education

|  |  |  |  |
| --- | --- | --- | --- |
| High School: |  | Address: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| From: |  | To: |  | Did you graduate and do you have any desire to further your education? | YES[ ]  | NO[ ]  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Other: |  | Address: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| From: |  | To: |  | Did you graduate? | YES[ ]  | NO[ ]  | Degree: |  |

## Diagnosis

Please list current providers and diagnosis

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Care Doctor |  | Phone #: |  |
| Psychiatrist: |  | Phone #: |  |
| Diagnosis: |  |
|  |  |  |  |
| Diet Restrictions |  | Medical Issues: |  |
| : |  | : |  |
| Current Meds: |  |
|  |  |  |  |

## Previous Treatment/Hospitalizations

|  |  |  |  |
| --- | --- | --- | --- |
| Provider: |  | Phone: |  |
| Address: |  | Service Received: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Reason: |  | : |  | : |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| From: |  | To: |  | Discharged to: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Are you still receiving services from this provider? | YES[ ]  | NO[ ]  |  |
|  |  |  |  |
|  |  |  |  |
| Provider: |  | Phone: |  |
| Address: |  | Service Received: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Reason: |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| From: |  | To: |  | Discharged to: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Are you still receiving services from this provider? | YES[ ]  | NO[ ]  |  |
|  |  |  |  |
|  |  |  |  |
| Provider: |  | Phone: |  |
| Address: |  | Service Received: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Reason: |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| From: |  | To: |  | Reason for Leaving: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Are you still receiving services from this provider? | YES[ ]  | NO[ ]  |  |

## Expectations of Service

|  |  |
| --- | --- |
| Goals: |  |

What do you want to get from this program?

|  |  |
| --- | --- |
| Any triggers or restrictions: |  |

i.e. being around children, physical challenges, deafness or hearing impairment, incontinence

|  |  |
| --- | --- |
| Generally helpful info for staff: |  |

## Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

DCI use only

Application received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staffed on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted or Denied

Reason for denial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source notified of decision on : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_