

Help in the Home, LLC
Maryland
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Application for Services

General Information

1. Name: _____ Social Security Number: _____

2. Date of Birth: _____ Present Age: _____ Race: _____ Gender: _____

3. Marital Status: _____

4. Briefly describe the reasons services are being sought at this time:

5. What does the client see as his/her problem? _____

6. What does the family member see as the client's problem? _____

7. What does the client/family want to accomplish through the establishment of a Personal Service Plan? _____

8. Current DSM Diagnosis
Axis I: _____
Axis II: _____
Axis III _____
Axis IV (List Issue Areas) _____
Axis V: Current _____ Highest in past year: _____

9. Current medications: list medication with dosage and times taken:

10. Can client self administer medication? Yes _____ No _____ If no please describe assistance needed _____

Help in the Home - Application for Services

11. Current address/telephone number and length of stay there:

12. Describe the client’s residential history. Start with the most current and go back approximately 3 years (i.e. living independently, with family members, in group home).

13. What strengths, attitudes, abilities, and behaviors have helped the client live successfully in the community in this past year? What will help the consumer in the future? _____

14. What difficulties, attitudes, abilities and behaviors have made it hard for the client to live successfully in the community this past year? What difficulties may make it hard in the future?

Physical Health:

List Allergies to Medications _____

1. Medical conditions client is currently receiving treatment for (e.g., hypertension, diabetes) and current status (in remission, monitored by physician, self monitored, need treatment, unstable). Indicate the name and phone number of treating physician.

Client reports being in good health. Date of last physical: _____

*Medical Condition	Current Status	Treating Physician/Phone
1.		
2.		
3.		
4.		

2. Describe significant medical conditions/problems client was treated for in the past:

3. Does the client have difficulty with any of the following? If so, describe below.

Help in the Home - Application for Services

Sleep Speech Nutrition Ambulation Visual
 Hearing Eating Hygiene Exercise Other (specify)

Describe difficulty including duration of problem and frequency: _____

4. Daily intake of caffeine? None Describe: _____
5. Daily intake of nicotine? None Describe: _____
6. Nutritional Screening: Based on self report, report from direct care staff or family, or observation, indicate if the individual has had difficulty in any of the following areas.
 eating disorder special diet rapid / significant weight changes
 significant changes in eating habits
 Describe difficulty including duration of problem and frequency:

Psychiatric Treatment and History

1. Number of Hospitalizations in past year _____; past five years _____
2. Dates, place, reason for and duration of all previous psychiatric hospitalizations:

Date	Place	Reason for admission	Length of stay

Continue list on back of page if necessary.

3. Has the applicant been or is he/she now suicidal or homicidal? Yes _____ No _____
 If yes, please describe in detail: _____

4. Has client ever threatened or physically harmed anyone? No (go to C) Yes, When? Please describe incidents beginning with the most recent one. _____

Help in the Home - Application for Services

5. Has client ever hurt self or engaged in Self Injurious Behavior? No (go to 6) Yes (describe below)

6. Has the client been part of a restrictive behavior plan or been placed in physical or chemical restraints?
 No Yes describe:

7. Has client ever destroyed property? No Yes describe:

8. History of sexual abuse:

A) of being abused as a child _____ as an adult _____ both _____

B) Is applicant vulnerable to sexual abuse/ exploitation at this time?: Yes_____ No_____

C) Has applicant sexually abused others?: Yes_____ No_____

D) If yes, please explain: _____

9. Is applicant at risk for elopement or wandering? No Yes describe:

10. Is applicant currently at risk for or have a history of engaging in sexually risky behavior? No Yes describe: _____

11. Does the applicant currently or have a history of ingesting unusual substances? No Yes describe:

12. Does applicant have a history of substance use? If yes, describe below:

Substance Type	Route	Frequency	Date Last Used	Treatment received & outcome

13. Current Outpatient Psychiatrist: : None in past 2 years

Help in the Home - Application for Services

Name:	
Address:	
Phone #:	
Outcome:	

List previous psychiatrists below:

Name	Dates of treatment	Reason for termination

14. Current External Case Manager: None in past 2 years

Name:	
Address:	
Phone #:	
Outcome:	

List previous external case managers below:

Name	Dates of treatment	Reason for termination

15. Current Therapist: None in past 2 years years

Name:	
Address:	
Phone #:	
Outcome:	

List previous Therapists below:

Name	Dates of treatment	Reason for termination

16. Current Day Program: None in past 2 years years

Name:	
Address:	
Phone #:	
Outcome:	

List previous Day Programs below:

Name	Dates of treatment	Reason for termination

Help in the Home - Application for Services

17. Other services client has received during the past two years including behavior management, psychological evaluation, physical therapy, occupational therapy, or nursing services? None in past 2 years Yes (describe):

18. Describe the anticipated involvement in care of other service providers:

DEVELOPMENTAL/SOCIAL Information:

1. Cooperativeness: cooperative minimally involved uninvolved resistant
2. Day activities: work Day Program school/training other

3. Describe family of origin, including trauma, and loss issues:

4. Is there likely to be ongoing contact and visitation between the applicant and the family?
Yes ____ No ____, If yes, what are the names and phone numbers of the family members:

5. Spiritual affiliation: _____

6. Legal History

a. Power of attorney: Yes _____ No _____ - If yes, names _____

b. Legal Guardian: Yes _____ No _____ If yes, names _____

c. Arrested: Never _____ # of times _____, reason of each arrest: _____

d. Ever been sentenced: Never _____ # of times _____, If served "time" please state when, where and why: _____

e. Presently of parole or probation: Yes _____ No _____ If yes, name and phone Number of Parole/Probation officer: _____

f. Are there any court orders: Yes _____ No _____ If yes, state type of order: _____

g. Is there a conditional release: Yes _____ No _____

h. Any other legal issues unsettled for this applicant: _____

7. Describe applicant's friends / social supports:

Help in the Home - Application for Services

8. How well does client get along with others? interacts well some problems major difficulties other

9. How does client manage conflict with others?

10. What does client find stressful? How does s/he typically manage stress?

11. What are the signs related to relapse or decompensation?

12. Describe any significant growth and development milestones:

III. TRAINING/VOCATIONAL/EDUCATIONAL HISTORY

1. Highest grade completed in school? <12 years high school/GED 12-15 BA/BS 17+
2. What is/was client's overall experience with school? Describe behavioral or learning problems:

3. Is or has the client ever been in the military? No Yes, please describe veteran status, and history of service: _____

4. Summary of work history (type of jobs, duration and reasons for leaving):

5. Occupation: _____
Retired: Yes _____ No _____ Disabled: Yes _____ No _____

6. What are client's needs in the vocational or educational area that are to be addressed?

Financial Status:

SSDI _____ SSI _____ Pension _____ Trust _____ Allowance _____
 Employment _____ Other _____

Entitlements:

MA _____ Medicare _____
 Maryland Pharmacy Assistance _____ Private Insurance _____
 Food stamps _____ Other _____

Help in the Home - Application for Services

***Entitlements Needed** _____

Name and contact information of financially responsible party: _____

Name of Referring Person, Title (relationship to Applicant)

Signature of Referring Person

Date

In order to help us process this application, please provide as much information as possible. It is helpful to have the following: a current physical; a treatment summary from a mental health professional; a discharge summary for each hospitalization. This application may be faxed or submitted by email.

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