STEPS to Independence

APPLICATION

STEPS to Independence
(818) 779-5168
Program Director: Tara Reisbaum, treisbaum@thehelpgroup.org
Program Coordinator: Ngan Mork, nmork@thehelpgroup.org

PLEASE RETURN YOUR APPLICATION AND ALL DOCUMENTS TO:

The Help Group
STEPS to Independence
Ngan Mork, Program Coordinator
13130 Burbank Blvd.
Sherman Oaks, CA 91401

Please check each box to make sure the following are included. (*If not applicable, please mark N/A)*

[ ] Completed Application

[ ] Recent photo of applicant

[ ] Completed Applicant Questionnaire

[ ] Completed Parent Questionnaire

[ ] Copy of Medi-Cal Benefits Identification / Private Health Insurance Identification Card

[ ] Copy of Conservatorship, if applicable

[ ] Copy of applicant's Individual Program Plan (if a Regional Center Client)

[ ] Copy of applicant's last annual and triennial IEP or ITP, if available

[ ] Copy of most recent psychological evaluation, such as a WISC-III/IV, WAIS-R and/or Vineland

AUTHORIZATION AND AGREEMENT

I authorize investigation of all statements contained in this Application for Admission to STEPS to Independence as may be necessary in arriving at an admission decision. In the event of admission, I understand that false or misleading information, given in the application, or in any interviews, may result in rescission of any admission. I understand also that continued admission to STEPS requires the applicant to abide by all rules and regulations of the program.

____
Applicant Signature Date

____
Parent/Legal Guardian Signature Date

DATE OF APPLICATION: ____________________________________

I. APPLICANT INFORMATION

______________________ ______________________ ______________________
LAST NAME FIRST NAME MIDDLE NAME

____(____)__________
STREET ADDRESS CITY STATE/ ZIP HOME PHONE

CURRENT RESIDENCE:

[ ] PARENT'S HOME [ ] INDEPENDENT LIVING [ ] GROUP HOME

[ ] OTHER: ____
PLEASE SPECIFY

DATE OF BIRTH: _____/_____/_____ AGE: _________

[ ] MALE [ ] FEMALE

____
CITY OF APPPLICANT'S BIRTH STATE COUNTRY

______________________________________ ______________________________________
SOCIAL SECURITY # MEDI-CAL # or INSURANCE CARRIER & POLICY #

PRIMARY LANGUAGE: ____

LANGUAGES SPOKEN IN THE HOME: ____

REGIONAL CENTER INFORMATION:

[ ] Check here if applicant is *not* a regional center consumer.

______________________________________ ______________________________________
SERVICE COORDINATOR PHONE NUMBER

____
STREET ADDRESS CITY STATE ZIP

____
DATE OF MOST RECENT IPP

PLEASE LIST CURRENT SERVICES BEING PROVIDED BY THE REGIONAL CENTER:
(*If more space is needed, please use COMMENTS section below*)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

CONSERVATORSHIP INFORMATION:

[ ] Check here if applicant is *not* conserved.

______________________________ ______________________________
NAME OF CONSERVATOR DATE OF CONSERVATORSHIP

____
STREET ADDRESS CITY STATE ZIP

(____)______________________________ ______________________________
PHONE # E-MAIL ADDRESS

EMERGENCY CONTACT INFORMATION:

______________________________ ______________________________
NAME RELATIONSHIP

____
STREET ADDRESS CITY STATE ZIP

(____)______________________________ (____)______________________________
PHONE # ALTERNATE PHONE #

COMMENTS:
(Please use this section to discuss any special legal circumstances related to the applicant)

II. FAMILY INFORMATION

[ ] Check here if there is *no* family involvement.

MOTHER'S INFORMATION:

____
NAME

____
STREET ADDRESS (if different that applicant's)

____
PHONE: circle one: HOME / WORK / MOBILE

____
E-MAIL ADDRESS

EMPLOYMENT INFORMATION

____
NAME OF EMPLOYER

____
JOB TITLE/POSITION

____
STREET ADDRESS

____
CITY STATE ZIP

_(______)______________________
WORK PHONE NUMBER EXTENSION

FATHER'S INFORMATION:

____
NAME

____
STREET ADDRESS (if different that applicant's)

____
PHONE: circle one: HOME / WORK / MOBILE

____
E-MAIL ADDRESS

EMPLOYMENT INFORMATION

____
NAME OF EMPLOYER

____
JOB TITLE/POSITION

____
STREET ADDRESS

____
CITY STATE ZIP

_(______)______________________
WORK PHONE NUMBER EXTENSION

SIGNIFICANT FAMILY MEMBERS/SIBLINGS:

NAME: ______________________ AGE: ________ RELATIONSHIP: ______________

NAME: ______________________ AGE: ________ RELATIONSHIP: ______________

NAME: ______________________ AGE: ________ RELATIONSHIP: ______________

OTHER HOUSEHOLD MEMBERS:

NAME: ______________________ AGE: ________ RELATIONSHIP: ______________

NAME: ______________________ AGE: ________ RELATIONSHIP: ______________

NAME: ______________________ AGE: ________ RELATIONSHIP: ______________

III. MEDICAL HISTORY

NAME OF PRIMARY CARE PHYSICIAN ______________________ PHONE NUMBER ______________________

STREET ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

DATE OF MOST RECENT PHYSICAL ______________________

Does the applicant have any chronic or serious health conditions? [ ] YES [ ] NO
If yes, please describe:

Does the applicant have any health restrictions or limitations? [ ] YES [ ] NO

If yes, please describe: ______________________

Does the applicant have any allergies? [ ] YES [ ] NO
If yes, please describe: ______________________

Is applicant currently taking any medication? [ ] YES [ ] NO
If yes, please list.*

MEDICATION	**DOSAGE/TIMES**	**PRESCRIBING DR.**	**PURPOSE**

*(*if more space is needed, please use COMMENTS section on page 7)*

Applicant takes medication:
[ ] INDEPENDENTLY
[ ] WITH SUPERVISION/REMINDERS
[ ] WITH ASSISTANCE
[ ] ONLY WHEN ADMINISTERED BY CAREGIVER

Has the applicant been hospitalized in the past 3 years? [ ] YES [ ] NO
(if yes, please explain below)

1. Reason: ____

Name of Hospital: ______________________________ Date of Hospitalization: ____________

Duration: ____

2. Reason: ____

Name of Hospital: ______________________________ Date of Hospitalization: ____________

Duration: ____

Comments:

IV. EDUCATIONAL SERVICES:

Applicant currently participates in a:

[ ] DAY PROGRAM [ ] WORK TRAINING PROGRAM [ ] COMPETITIVE EMPLOYMENT

[ ] NONE [ ] OTHER, please specify:______________________________

______________________________ ______________

NAME OF CURRENT PROGRAM/EMPLOYER DATE STARTED

____

STREET ADDRESS CITY STATE ZIP

______________________ (_____)______________________

CONTACT PERSON PHONE NUMBER

____

NAME OF LAST HIGH SCHOOL ATTENDED

____

STREET ADDRESS CITY STATE ZIP

(_____)______________ ______________ ______________

PHONE NUMBER DATE STARTED DATE ENDED

Applicant received a: [ ] DIPLOMA [ ] CERTIFICATE OF COMPLETION

Has the applicant ever applied to any other program at The Help Group? [ ] YES [ ] NO

If yes, which program, and what was the outcome? ______________________________

____

____

____

____

V. <u>HISTORY OF INTERVENTIONS:</u>

A. Diagnosis

Has the applicant been diagnosed with a developmental or learning disability? [ ] YES [ ] NO

If yes, please specify: ____

Who diagnosed the applicant? ______________________________(____)________
NAME AGENCY PHONE NUMBER

Date of diagnosis: ____________________

B. Please indicate if applicant has received or is currently receiving services in any of the following areas:

1. Speech and Language ________________________(____)______________
NAME OF SERVICE PROVIDER PHONE NUMBER

When was applicant last assessed for these services? ______________________________

What are the goals of this intervention? ______________________________

2. Counseling ________________________(____)______________
NAME OF SERVICE PROVIDER PHONE NUMBER

When was applicant last assessed for these services? ______________________________

What are the goals of this intervention?______________________________

3. Occupational Therapy ________________________(____)______________
NAME OF SERVICE PROVIDER PHONE NUMBER

When was applicant last assessed for these services? ______________________________

What are the goals of this intervention? ______________________________

4. Educational Therapy or Tutoring ________________________(____)______________
NAME OF SERVICE PROVIDER PHONE NUMBER

When was applicant last assessed for these services? ______________________________

What are the goals of this intervention? ______________________________

<u>Please provide any assessments completed by the professionals above or any other assessments you may have had within the past 3 years.</u>

VI. ADDITIONAL INFORMATION:

For each question identified below, place an X in the box to the right that appropriately describes the applicant.	Often	Sometimes	Rarely	Never
1. The applicant prefers to do things with others rather than on his / her own.				
2. The applicant prefers to do things the same way over and over again.				
3. The applicant has been involved in physical fights at school/program/job site.				
4. The applicant has been suspended from school/program/work.				
5. The applicant often notices small sounds when others do not.				
6. In a social group, applicant can easily keep track of several different people's conversations.				
7. The applicant has made inappropriate sexual statements.				
8. The applicant has engaged in inappropriate sexual activities on one or more occasions.				
9. Applicant finds social situations easy.				
10. When applicant talks, it isn't always easy for others to get a word in edgewise.				
11. The applicant finds it hard to make new friends.				
12. It upsets the applicant if the daily routine is disturbed.				
13. The applicant finds it easy to "read between the lines" when someone is talking to me.				
14. New situations make the applicant anxious.				

Please describe any behavioral problems that have been brought to your attention by the school/program/work site staff.

____

____

____

VII. REFERRAL SOURCE

Please provide the following information regarding the person or organization that referred you to STEPS to Independence.

____

NAME AGENCY

____

STREET ADDRESS CITY STATE ZIP

____

PHONE NUMBER

VIII. PERSONAL REFERENCES:

Please provide contact information of two professionals that know the applicant well and can provide information to assist in the development of his/her service plan. These can be previous employers, supervisors, educational or vocational staff, or clinicians.

1.____________________________________ ____________________________

NAME OF PERSON RELATIONSHIP

____

STREET ADDRESS CITY STATE ZIP

(_____)______________________________ ____________________________

PHONE NUMBER E-MAIL ADDRESS

2.____________________________________ ____________________________

NAME OF PERSON RELATIONSHIP

____

STREET ADDRESS CITY STATE ZIP

(_____)______________________________ ____________________________

PHONE NUMBER E-MAIL ADDRESS