

John Elias Baldacci
Governor



John R. Nicholas
Commissioner

Maine Department of Health and Human Services

Applicant First Name:	Middle Name:	Last Name:	Suffix:
Legal Address:	City/Town:	State:	Zip Code:
Mailing Address:	City/Town:	State:	Zip Code:

Telephone Number: _____

Other Names: _____

Social Security Number:	DOB:	Age:
Maine Care Number:	Medicare Number:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Place of Birth:	

<u>RACE</u>	
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	Ethnicity: _____ Primary Language: _____

<u>ENGLISH PROFICIENCY</u>	
<input type="checkbox"/> Not Proficient <input type="checkbox"/> Read <input type="checkbox"/> Read/Speak/Write <input type="checkbox"/> Read/Understand <input type="checkbox"/> Read/Understand/Write <input type="checkbox"/> Read/Write <input type="checkbox"/> Speak <input type="checkbox"/> Speak/Read <input type="checkbox"/> Speak/Read/Write	<input type="checkbox"/> Speak/Understand <input type="checkbox"/> Speak/Understand/Read <input type="checkbox"/> Speak/Understand/Read/Write <input type="checkbox"/> Speak/Understand/Write <input type="checkbox"/> Speak/Write <input type="checkbox"/> Understand <input type="checkbox"/> Understand/Write <input type="checkbox"/> Write <input type="checkbox"/> Unknown

CRITICAL INFORMATION

ALERTS: _____

MEDICAL

ALLERGIES TO MEDICATIONS: _____

ALLERGIES TO NON-MEDICATIONS: _____

DIABETES: _____

INSULIN INJECTION DEPENDENT: _____

MEDICATION: _____

OTHER: _____

SEIZURES: _____

NECESSARY ACCOMODATIONS

AUDIO AMPLIFICATION: Yes No

Comments: _____

COMMUNICATION BOARD: Yes No

Comments: _____

INTERPRETER/FOREIGN LANGUAGE: Yes No

Comments: _____

INTERPRETER/SIGN: Yes No

Comments: _____

TTY: Yes No

Comments: _____

WHEELCHAIR: Yes No

Comments: _____

OTHER: _____

EDUCATION

School Attended/Attending:			
Current Grade Level (if applicable)		Highest Level Achieved:	
Expected Date of Graduation			
Comments:	_____		

LIVING ARRANGEMENTS

Type of Living Arrangement: <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Related Persons <input type="checkbox"/> Lives with Unrelated and Related Persons <input type="checkbox"/> Lives with Unrelated Persons Household Composition: _____	Description:
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RELATIONSHIPS/ASSOCIATIONS

GUARDIAN

First Name:	Last Name:	Telephone #:	
Address:	City/Town:	State:	Zip Code:

CO - GUARDIAN

First Name:	Last Name:	Telephone #:	
Address:	City/Town:	State:	Zip Code:

CONSERVATOR

First Name:	Last Name:	Telephone #:	
Address:	City/Town:	State:	Zip Code:

REPRESENTATIVE PAYEE

First Name:	Last Name:	Telephone #:	
Address:	City/Town:	State:	Zip Code:

PHYSICIAN

First Name:	Last Name:	Telephone #:	
Address:	City/Town:	State:	Zip Code:

Other Relationships (Please Specify)

First Name:	Last Name:	Telephone #:	
Address:	City/Town:	State:	Zip Code:

First Name:	Last Name:	Telephone #:	
Address:	City/Town:	State:	Zip Code:

Case Management

Instruction: Check all that apply

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Individual Support Coordinator – State	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Case Management (Adult)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Case Management (Children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Member ISC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Legal /Regulatory Services

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Guardian – Public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guardian – Private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conservator – Public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conservator – Private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correspondent – CAB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correspondent – Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Financial Services

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
BDS Representative Payee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Representative Payee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mortuary Trust (Over Age 50)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Environmental Modification/Adaptive Equipment

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Environmental Access Modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Non – Access Modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adaptive Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Safety

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Emergency Prevention Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Crisis Behavior Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Community Activities

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Religious Spiritual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Housing

Type of Housing:	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Own Apartment/Home (No Support)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Own Apartment/Home (Partial Support)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living with parents/relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boarding/Lodging House	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisted Living Program (Congregate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unlicensed Residential Care Facilities (1-2 Beds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level I Residential Care Facilities (1-2 Beds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level II Residential Care Facilities (3-6 Beds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level III Residential Care Facilities (3-6 Beds, Level I plus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level IV Residential Care Facilities (7 or more Beds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICF/MR Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICF/MR Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General ICF Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless/Shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital – Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital – Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Treatment – Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Treatment – Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correctional Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correctional Halfway House	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Support:	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Occasional family respite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-scheduled or on-call assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regularly scheduled part-time assistance and/or supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 hour on site assistance with intensive medical and/or behavioral supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 hour on site assistance and training available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support of Housemates and/or relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Planned Respite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Describe current services: _____

Comments: _____

Day/Evening Services

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Day Habilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Enrichment Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Education

Education Type:	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Public/Private School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Secondary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Vocational School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transition Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Transportation

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Transportation – Routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation – Non – Scheduled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Work

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Community Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sheltered Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Personal Supports

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Family Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vacation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Contact/Visitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homemakers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent support/Skills training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Funeral Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self – Advocacy Training/Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexuality Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Personal Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify other personal services: _____

Describe current services: _____

Comments: _____

Evaluation and Treatment Services

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
Audiological Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify Medical Specialist			
Annual Medical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last Annual Medical Exam Date:			
Home Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annual Dental Date:			
Dental IV Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy – Day Hab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy – Home Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy – Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy – Day Hab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy – Home Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy – Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psycho-active Med Review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of Last Eye Examination:			
Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Routine Crisis Team Contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Communication

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
English as a second language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy – Day habilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy – Home Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy – Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sign Language Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestural Language Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picture Books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facilitated Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____

Waiver Services

	CURRENTLY RECEIVES	IMMEDIATE NEEDS	POTENTIAL NEED (2-5 YRS)
W102 Psychological Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W103 Speech Therapists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W104 Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W105 Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W110 Day Habilitation Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W111 Residential Training Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W112 Residential Training Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W113 Residential Training Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W114 Residential Training Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W115 Residential Training Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W116 Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W117 Respite Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W119 Communication Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W121 Crisis Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W122 Environmental Modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W125 Personal Support Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W126 Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W127 Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W130 Facilitated Communication (Consultation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W131 Facilitated Communication (Evaluation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe current services: _____

Comments: _____