Disabilities Network of Eastern CT – Application for Services

Applicant Information

Name:	Home Phone:	Notes:
Address:		
City:	Work Phone:	Notes:
State:		
Zip:	Cell Phone:	Notes:
Email Address:		
Income Level: $	Staff Name & Date:	
Insurance Type: (circle) Private Medicaid Medicare Other (describe)		

disability type

1) Cognitive
2) Mental Health
3) Physical
4)Visual
5) Hearing
6) Multiple Disability
7) Decline

-Do you…

- have a physical or mental impairment that substantially limits your ability to function independently in your family, community or employment, and
- believe that independent living services will improve your ability to function independently in your family, community or employment? *

ϒ Yes ϒ No ϒ Not Sure

-If you checked "Yes" or "Not Sure," how does your disability affect your ability to be independent?

I require additional support.

-The center can provide services to you with or without an independent living plan (ILP). Has the center's staff explained what an ILP is, provided you with a sample ILP and offered to assist you to develop an ILP?

ϒ Yes ϒ No

-Do you want to develop an ILP? Answering "No" means that, at this time, you have decided that an ILP is not necessary and that you have voluntarily waived the development of an ILP.

ϒ Yes ϒ No

Requested Services

Support services from DNEC to obtain an ILP goal.

For ILC Staff: I have determined this applicant to be **eligible/ ineligible** (circle one) for IL services

Staff Signature _____ Date _____

*From the Rehabilitation Act Amendments of 1992

To the Applicant:

The remaining questions of this form are optional. If you choose to answer these questions, the information collected will remain confidential and will be reviewed by the center to ensure that we are meeting our mandated to serve people with all types of disabilities, of all ages and from all ethnic/racial groups.

Specific Disability **Primary:** _____ **Secondary:** _____

1) Amputation	8) HIV/ AIDS	15) Respiratory/ Heart
2) Cerebral Palsy	9) Learning Disability	16) Spinal Cord Injury
3) Chemical Dependency	10) Mental Health	17) Stroke/ CVA
4) Diabetes	11) Mental Retardation	18) Traumatic Brain Injury
5) Environmental Illness	12) Multiple Sclerosis	19) Visual
6) Epilepsy	13) Muscular Dystrophy	20) Other
7) Hearing	14) Polio/ Post Polio	21) Declined

Specify Other:

Birthday: _____ **Age:** _____ **Gender:** _____

Ethnicity/ Race: _____

1) African-American	5) Latino/a
2) American Indian/Alaskan	6) Asian
3) Native Hawaiian/Pacific Islander	7) Multi-Cultural/Other
4) Caucasian	8) Declined

Living Situation: _____

1) Institution	4) Independent
2) Living with & dependent on family/ friends	5) Other
3) Assisted Living	6) Declined

Veteran Status: _____

Is Applicant a Veteran? ϒ Yes ϒ No

Is disability service related? ϒ Yes ϒ No

Referral Source: _____

1) Agency	4) Business	7) DMH	10) Employer	13) ICF/ SNF	16) Self
2) BESB	5) CAP	8) DDS	11) Family/Friend	14) P&A	17) Other
3) BRS	6) CDHI	9) DSS	12) Hospital/Medical	15) School	18) Declined

If number 1, 4, 10, 12, 13, 15, & 17, specify:

Social Security: _____ **Title 19:** _____

The center's programs have been explained to me. I have been advised of my rights and responsibilities as a participant of the center's programs and I have received information on the Client Assistance Project (CAP). I have been advised that by participating in this program my participant record may be entered into our electronic database as well as made available to the Bureau of Rehabilitation Services (BRS) for their financial and programmatic auditing of the center's programs.

_____ _____ _____

Applicant's Signature | Date | Parent and/ or Guardian