

APPLICANT INFORMATION					
Last	MI	First	Email		
Street Address	City	ST	Zip	Home Phone	Mobile Phone
DOB					
CONTACT INFORMATION					
Last	MI	First	Email		
Relationship to Applicant					
Street Address	City	ST	Zip	Home Phone	Mobile Phone
EMERGENCY CONTACT INFORMATION					
Last	MI	First	Email		
Relationship to Applicant					
Street Address	City	ST	Zip	Home Phone	Mobile Phone
APPLICANT MEDICAL HISTORY					
Please use a number to describe your following interference level 1=None 2= Mild 3=Moderate 4= Constant					
Mobility		Confusion		Ability to Self Correct	
Strength		Anxiety		Frustration Tolerance	
Speech Intelligibility		Distractibility		Impulsivity	
Hostility		Problem solving		Following Directions	
EMPLOYMENT/DAY PROGRAM HISTORY					
Employer					
Address					
City, ST, ZIP					
Telephone					
Name of Immediate Supervisor					
Position/Job Title					
Length of Employment/day program	FROM		TO		
Do you receive SSI/SSA/SSDI? YES NO					
Do you receive Medicaid Personal Care Funding? YES NO					
Are you a client of the Division of Developmental Disabilities? YES NO					
HOBBIES, INTERESTS, SPORTS, ETC					
GENERAL INFORMATION					
Does your child currently live in the family home? YES NO					
Has your child ever lived away from you? YES NO					
Why do you want your child to be considered to live an Adult Family Home?					
REFERENCES					
Please list three reference names, addresses and phone numbers					
Name	Address			phone	
Name	Address			phone	
Name	Address			phone	
Disclaimer - By signing, I hereby certify that the above information, to the best of my knowledge, is correct.		Signature		Date	