

Please check which service(s) you are applying:

Community Residential Alternative (CRA)
 Host Home/Life Sharing (CRA)
 Community Living Supports (CLS)
 Community Access Group (CAG)



**Intellectual & Developmental
 Disabilities Services**
 Jewish Family & Career Services

Application For IDD Services

Name of Applicant:		Date of Application:	
Street Address:			
City, State, Zip:		County:	
Gender: Male or Female		DOB:	
SS#:		Email:	
Race (optional, select all that apply)*: American Indian or Alaska Native Black/African American White Multiracial Asian Native Hawaiian or Other Pacific Islander Other Decline Ethnicity (optional)*: Hispanic Not Hispanic or Latino Other Spanish Origin			
*Applicants are considered for eligibility on the basis of qualification/appropriateness of fit, without regard to any classification protected by state or federal law, including race, color, religion, sex, national origin, age, veteran status, or disability.			
Home Phone:		Cell Phone:	
		Work Phone:	
Intellectual and/or Developmental Disability:			
Do you have a Legal Guardian? Yes or No		Referral Source:	
Name of Guardian/Family Representative:		Relationship:	
Street Address:			
City/State/Zip:		Email:	
Home Phone #:		Work Phone #:	
Cell Phone #:			

FOR OFFICE USE ONLY

Program Manager Approval: ☐ Yes ☐ No Signature:		Date:
Registered Nurse Approval: ☐ Yes ☐ No Signature:		Date:
IDD Director Approval: ☐ Yes ☐ No Signature:		Date:
Date application received:		If not approved, date letter sent:

Please describe your desired outcome as a result of receiving our services:

Emergency Contact #2:		Relationship:
Street Address:		
City, State, Zip:		Email:
Home Phone #:	Cell Phone #:	Work Phone #:
Emergency Contact #3:		Relationship:
Street Address:		
City/State/Zip:		Email:
Home Phone #:	Cell Phone #:	Work Phone #:

Medical Information

Allergies:			
Diagnoses:			
Doctor	Name	Address	Telephone #
Primary			
Neurologist			
Dentist			
Psychiatrist			
Psychologist			
Gynecologist			
Other			
<i>Please note: A release form for each doctor must be submitted with application</i>			
I authorize JF&CS to seek and obtain medical care for _____ in the event that she/he needs medical care for healthcare management as well as emergency medical care at an urgent care, hospital or hospital emergency room. I agree to be responsible for the cost of any uncovered medical care provided to _____ under this authorization.			
Preferred Hospital:			DNR: ☐ Yes ☐ No <i>If yes, provide copy</i>

Previous Surgeries

Date	Type of surgery	Where was surgery performed?

Insurance Information

Name of Company	Group #	ID#
Do you smoke? ☐ Yes ☐ No		Do you drink alcohol? ☐ No ☐ Daily ☐ 1-6 x/week

Financial Information

Medicaid Waiver: ☐ COMP ☐ NOW ☐ Other:		
☐ Private Pay	If Private Pay, are you on the Medicaid Waiver Planning/Wait List? If so, name of Planning List Administrator:	
Support Coordination Agency, Coordinator, Phone #:		
Type of Social Security:	Monthly Amount Received:	
Representative Payee:		
Are you currently employed? If so, where?		High School Diploma/GED: ☐ Yes ☐ No
Supported Employment Agency:	Job Coach name:	Job Coach Phone #:

Behavioral Information

Do you have a Behavior Support Plan? ☐ Yes ☐ No	
Behavior Specialist Name:	Phone #:
What challenging behaviors do you need support with?	
Has your provider or family ever had to contact GCAL about your behavior?	
Have you ever been arrested?	
Have you ever been charged with a misdemeanor or felony?	
Were you convicted?	

Cultural Preferences

What is your primary language?
What religion do you practice, if any?
What supports do you need to practice your religion or other cultural needs (i.e. worship, customs)?
Please specify any household requirements:

Current Provider:	Contact Name: <i>Signed Release needed to contact</i>	Phone #:
Previous Provider:	Contact Name: <i>Signed Release needed to contact</i>	Phone #:

Other information you'd like to provide:

Supplemental Documentation

☐ Evaluation by a licensed professional documenting diagnosis of a developmental disability prior to age 22	☐ Physical Examination results within the last year including copy of immunization record, & negative TB test
☐ Copy of proof of citizenship (social security card or birth certificate)	☐ Copy of photo identification (state-issued photo ID or passport)
☐ Copy of medical insurance cards (required prior to initiating services)	☐ Copy of guardianship papers/Power of Attorney if applicable
☐ Signed release of information from each doctor (required prior to initiating services)	☐ Signed release of information from each former service provider (required prior to initiating services)
☐ Copy of Advanced Directives (a blank copy will be provided to you upon request)	☐ Copy of Behavioral Assessment/Support Plan, if applicable

Attestation Statement

I attest to the fact that this application is a true representation of my support needs and the information is accurate to the best of my knowledge. I understand that submitting an application does not guarantee admission into programs or services.

Applicant Signature: _____ Date: _____

Guardian/Family Signature: _____ Date: _____