Independent Living, Inc.
"Making Dreams A Reality"
Like Us On Facebook.

206 South Cherry St., Ste. D
P.O. Box 2300
Harrison AR, 72602-2300
870-741-6909 office
870-741-4549 fax
info@i-living.org

Application for Services

Application Components:

1. Identifying Information
2. Social History Information (8 pages)
3. Residency Information
4. Education/Vocational Information
5. Health Information
6. Financial Information

Items to Submit With Application:

1. A recent photograph
2. A copy of applicant's birth certificate
3. A copy of applicant's social security card
4. A copy of applicant's immunization records
5. A copy of applicant's most current SSI check (if applicable)
6. A copy of applicant's most current SSA check (if applicable)
7. A copy of applicant's Medicaid card (if applicable)
8. A copy of applicant's Medicare card (if applicable)
9. Applicant's guardianship/power of attorney court orders (if applicable)
10. Applicant's medical records if diagnosed with Cerebral Palsy, Epilepsy, Autism or Mental Retardation.
11. Applicant's most recent psychological evaluation
12. Applicant's most recent IPP/IEP/ISP (if applicable)
13. Speech, physical, or occupational therapy reports (if applicable)
14. Discharge summaries from any program and or hospital stays in the last two years.

Please mail the completed application along with the above items to the address below. Once the information is received, Independent Living, Inc. will determine whether the applicant is appropriate for services. You will be contacted and notified of the determination. Thank you for considering Independent Living, Inc.

Independent Living, Inc.
P.O. Box 2300
Harrison, AR 72602-2300

If you have received an incomplete application, or for additional information, please contact ILI at (870) 741-6909 or email at info@i-living.org

Social History

Applicant's Full Name: _____

Date of Birth: _____ Sex: Male ____ Female: ____

Place of Birth: _____

Mother's Full Name: _____ Level of Education: _____

Mother's Occupation: _____

Father's Full Name: _____ Level of Education: _____

Father's Occupation: _____

Names of Siblings: Age: Level of Education: Occupation:

_____

_____

_____

_____

Please list if the applicant is his/her own legal guardian. Yes No

If no please list applicant's guardian/power of attorney information.

Name Address Phone # Relationship to applicant

_____

_____

Please give a brief description of the applicant's personality (behaviors, hobbies, likes, and dislikes, etc)

_____

_____

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_____

Please describe any challenging or negative behaviors (type, frequency, trigger, resolution, etc)

_____

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_____

_____

_____

Please describe activity level (Circle one) Low Moderate High

Please describe aggression level (Circle one) Low Moderate High

Please describe any self-stimulating behaviors (type, frequency, triggers, etc)

_____

_____

_____

Please describe any possible injurious behaviors towards others or self-inflicted.

_____

_____

_____

Please describe the type of assistance the applicant requires in the following areas:

Eating: _____

Dressing: _____

Toileting: _____

Mobility: _____

Bathing: _____

Grooming: _____

Meal Prep/Cooking: _____

Budgeting/Shopping: _____

Cleaning/Chores: _____

Laundry: _____

Transportation: _____

Other: _____

Health Information

Applicant's current physician: _____

Address: _____ Phone #: _____

Please list the applicant's physical description:

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Scars/Tattoos: _____

What is the applicant's primary diagnosis?

Mental Retardation ____ Autism ____ Cerebral Palsy ___ Epilepsy/Seizures ____

Down syndrome ____

Other diagnosis/Medical conditions: (Diabetes, High Blood Pressure, etc)

_____

_____

_____

Please describe seizure activity (type, frequency, treatment, etc)

_____

_____

_____

Is the applicant ambulatory? Yes or No

If no, please describe: _____

Is applicant verbal? Yes or No

If no, please describe applicant's ability to communicate:

_____

_____

_____

Please list any allergies to food, medications, etc and the treatment used in the event the applicant is exposed.

_____

_____

_____

Please list all over the counter/prescribed medications the applicant is currently taking.

Medication: Dosage: Reason:

_____

_____

_____

_____

_____

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_____

Please list and describe any special health or medical concerns regarding the applicant in detail.

_____

_____

_____

_____

_____

Please list the applicant's insurance information.

Medicaid # _____ Medicare # _____

Private Insurance Company/Other:

Insurance Company: _____ Policy # _____

Address: _____ Phone #: _____

Life Insurance Company: _____ Policy # _____

Burial Insurance Company: _____ Policy # _____

Residency Information

Please describe the applicant's current living arrangements, including place of residence, length of stay, others in the home, and reason for leaving/moving.

_____

_____

_____

_____

_____

Applicant's current phone # _____

What type of living arrangement is the applicant seeking?

_____

_____

_____

_____

Please list the places the applicant has lived in the past ten years, the approximate dates of residence, whether it was a hospital or other facility, and if so, the name of the hospital/facility.

City/State (Dates) To/From Hospital/Facility Y or N Name of Hospital/Facility

_____

_____

_____

Has the applicant ever lived in a H.U.D. funded apartment/house/facility? Yes No Don't Know

If yes list when and where? _____

Has the applicant ever been evicted from a H.U.D. funded apartment/house/facility? Yes No Don't Know

If yes list when and where _____

Has the applicant ever served in the US military? Yes No Don't Know

If yes list when, what branch, and type of discharge: _____

Education/Vocational Information

Please list the applicant's educational history:

School Dates Location Grade completed

_____

_____

_____

_____

Did the applicant graduate from high school or receive a Certificate of completion? Yes No Don't Know

Please list any information regarding vocational training the applicant has completed or may have participated in, including current programs and day centers.

Location Dates Type of Training Reason for Leaving

_____

_____

Has the applicant ever received services from Arkansas Rehabilitation Services? Yes No Don't Know

If yes please list when and where: _____

Please list the applicant's employment history if any exists.

Employer Dates Job Duties Reason for Leaving

_____

_____

_____

_____

Please list any special skills the applicant has that would be helpful in seeking and obtaining employment.

_____

_____

_____

_____

Financial Information

Dose the applicant have a savings account? (Circle one) Yes No Don't Know
If yes please list the following:
Name of the financial institution: _____
Current balance: _____

Dose the applicant have a checking account? (Circle one) Yes No Don't Know
If yes please list the following:
Name of the financial institution: _____
Current balance: _____

Does the applicant have a trust fund? (Circle one) Yes No Don't Know
If yes please list the following:
Name of the financial institution: _____
Current balance: _____

Does the applicant receive SSI benefits? (Circle one) Yes No Don't Know
If yes, applicant's monthly benefit amount: _____

Does the applicant receive SSA benefits? (Circle one) Yes No Don't Know
If yes, applicant's monthly benefit amount: _____

Does the applicant have income from employment? (Circle one) Yes No Don't Know
If yes, average monthly income: _____

Does the applicant have any other source of income? (Circle one) Yes No Don't Know
If yes, list source and amount: _____

Does the applicant have any outstanding debts? (Circle one) Yes No Don't Know
If yes, list type and amount: _____

Does the applicant have a representative payee? (Circle one) Yes No Don't Know
If yes, list payee's name: _____

Signature of person completing form: _____ Date: _____