RESOURCES FOR HUMAN DEVELOPMENT
Shared Living

2200 S. Minnesota Ave.
Sioux Falls, SD 57105
Phone: (605) 271-1882
Fax: (605) 275-6490

Application for Services

Reason for Referral:

Applicant Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Sex: ☐ Female ☐ Male

Current Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Family Contact: _____
(First) (Middle) (Last) (Relationship)

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Additional Contact: _____
(First) (Middle) (Last) (Relationship)

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SCHOOL INFORMATION – Check all that apply

- ☐ Currently attending school — Date services projected to end: _____
- ☐ Graduated with signed diploma — Date services ended: _____
- ☐ Received certificate of completion — Date services ended: _____

School: _____ Contact Person: _____ Phone: _____

LEGAL REPRESENTATIVE/CONSERVATORSHIP – Check all that apply to the applicant if over 18 years old

- ☐ Court Ordered Legal Representative and type: _____
- ☐ Court Ordered Conservator and Name: _____
- ☐ Power of Attorney and type: _____
- ☐ No Legal Representative in place

Legal Representative's Name: _____

Address: _____

Email: _____ Phone: _____

SERVICES REQUESTED – Check all that apply

- ☐ **Educational Services** Requested Start Date: _____

  ____ Integrated Classroom ____ Self-Contained Classroom

- ☐ **Employment Services** Requested Start Date: _____

  ____ Day Services

  ____ Supported Employment

  ____ Community Employment

- ☐ **Preferred Model of Service**
  - Companion Care → Home is leased/rented/owned by adult with disability
  - Host Home → Home is leased/owned/rented by person or family providing services
- ☐ **Residential Services** Requested Start Date: _____

____ Live with family	____ Group Home	____ 24 hr. support
____ Live alone	____ Supervised Apt	____ Daily support
____ Live with roommate	____ Rent Apt/Home	____ Weekly support
	____ Buy Home	____ Other

DEVELOPMENTAL DISABILITY DIAGNOSIS – Check all that apply

	Mild (52-70)		Down Syndrome		Fetal Alcohol Spectrum
	Moderate (36-51)		Cerebral Palsy		Traumatic Brain Injury
	Severe (20-35)		Epilepsy/Seizure Disorder		Cognitive Disability
	Profound (20 or below)		Autism		Other:
	Borderline (71-85)		Asperger's Disorder		Other:

FINANCIAL INFORMATION – Check all that apply

To assist in determining applicant's eligibility for services, please list sources and amounts of income:

Medicare Number	
Medicaid Number	
Social Security Number	
Rep Payee (if any)	

- ☐ Supplemental Security Income Amount: _____
- ☐ Social Security Disability Amount: _____
- ☐ Veteran's Administration Amount: _____

Other sources of income and amount: (ex: joint bank accounts, Indian Land Lease, trusts, stocks, bonds, wages, interest, property owned, etc)

_____

_____

_____

MEDICAL INFORMATION AND RELATED SERVICES – Check all that apply

- ☐ Speech/Language
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Counseling
- ☐ Psychiatric

Medical Diagnosis:

_____

_____

Medications

Name	Dosage	Frequency

Attach extra pages if applicable

Previous/Current Placements and Dates

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Conflict Free Case Manager: _____

Phone: _____ Email: _____

Provider: _____

Legal Convictions/History

☐ Yes ☐ No

If yes, please describe:

_____
_____
_____

I acknowledge this is a request for agency planning purposes. Completion of this form is not a guarantee of services nor is it a commitment on my part to accept offered services.

Applicant Signature: _____

Parent/Legal Representative Signature: _____

Date: _____

In addition to the application, please submit the following documents:

- ☐ ICAP
- ☐ ISP
- ☐ BSP
- ☐ Quarterly Reports
- ☐ Medical Review
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Social History
- ☐ PCT Tools
- ☐ POM Interview Information