

Philadelphia Independent Network
 Partners with - JEVs Human Services
 9350 Ashton Road, Suite # 201
 Philadelphia, PA 19114
 267-350-8678

Admissions Application for the
INDEPENDENCE NETWORK

Application Date: _____

Applicant Information

Name of Applicant:	Date of Birth:	Age:
Gender: <input type="radio"/> Male <input type="radio"/> Female	Marital Status:	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Living with partner
Address:	Phone:	
City/State/Zip	E-Mail:	

Estimated date you wish to enter the "Network" _____

How did you learn about the "Network" _____

Referred by: _____ Organization (if applicable) _____

Parent and Family Information

Father's Name:	Phone:
Address:	Cell Phone:
City/State/Zip:	Email:
Occupation:	Employer:

Mother's Name:	Phone:
Address:	Alternate #:
City/State/Zip:	Email:
Occupation:	Employer:

Sibling(s)

Name:	<input type="radio"/> M	<input type="radio"/> F	Age
Name:	<input type="radio"/> M	<input type="radio"/> F	Age
Name:	<input type="radio"/> M	<input type="radio"/> F	Age
Name:	<input type="radio"/> M	<input type="radio"/> F	Age

Other significant relative

Name:	Relation:
Address:	Phone:
City/State/Zip	Email:

Applicants Educational Information

High School:	Date completed:
College Name:	Date completed:
Other Post-Secondary Education (specify):	Date completed:
Type of Degree or Certificate received:	
College internships or job training programs attended:	

Has applicant ever been dismissed/suspended from school? Yes No

If yes, state reason/s:

Applicants Employment information

Current Employer:	Supervisor:
Address:	
Start date/average hours per week:	Job tasks:
Job coach services (name, agency, address and phone #	

Previous Employer:
Address:
Job tasks:
Dates of employment and average hours per week:

Has applicant ever been dismissed from employment? Yes No

If yes, state reason/s:

OVR

OVR application submitted: <input type="radio"/> Yes <input type="radio"/> No If yes, date submitted:	OVR office address:
OVR Counselor:	Phone #
Is there a OVR contract agency working with the applicant? <input type="radio"/> Yes <input type="radio"/> No	Contract agency name:

Benefits:

Financial benefits: SSI: \$_____ SSDI: \$_____ Other: \$_____
Medical benefits: <input type="radio"/> Medicaid _____ (ID #) <input type="radio"/> Medicare: _____ (ID #) <input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> Part D
<input type="radio"/> Other Health Insurance: _____ (name of policy) _____ (Policy #)
Food Stamps: <input type="radio"/> Yes <input type="radio"/> No If yes, current amount received: \$_____

Pennsylvania ODP (Office of Developmental Programs) Eligibility Information

<input type="radio"/> Submitted/In Process Date submitted: _____ Type of waiver: _____	
<input type="radio"/> Approved Date approved: _____	
<input type="radio"/> Denied <input type="radio"/> Never applied <input type="radio"/> Other: explain _____	
Date of Psychological Testing:	Testing conducted by organization/practitioner:
Test administered: <input type="radio"/> WAIS <input type="radio"/> Vineland II <input type="radio"/> ABAS II <input type="radio"/> Other:	

If testing was done, a copy of most recent psychological evaluation is needed. If no testing was completed, are you willing to complete a psychological evaluation? Yes No

ODP Services

Current ODP services-check those that are approved.

Waiver Eligibility subgroups

- OBRA
- Independence
- PFDS
- Consolidated
- Autism
- Comcare
- Medicaid Service Coordination

Agency: _____

Address: _____

Telephone: _____

Service Coordinator: _____

Services Received:

- At home residential habilitation (res hab)

Agency: _____

Address: _____

Telephone: _____

- Day habilitation

Agency: _____

Address: _____

Telephone: _____

- Supported Employment

Agency: _____

Address: _____

Telephone: _____

Medical information

- Please attach a copy of a medical examination completed within the past year.

List current medical conditions and any current or recent treatment:

Please list food allergies if applicable:

Medications

Current medications – name, frequency, and dosage: (or attach a medication list)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Is the applicant able to take medications independently? Yes No If no, what assistance is needed?

Other medical information

Any medical or psychiatric hospitalization(s) in the past 5 years? Yes No If yes, please indicate date, length of hospitalization and reason.

Is there any history of seizures? Yes No If yes, please describe.

Other clinical conditions (e.g. neurological, orthopedic, hearing, vision, etc.):

Is the applicant currently treated by a psychiatrist? Yes No If yes, please indicate the reason and attach a copy of a treatment summary.

Psychologist/social worker Name: _____ Phone: _____

Frequency of visits: _____

Adaptive and Independent living information

Has the applicant lived independently? Yes No - If yes, please specify where and for how long:

Has the applicant attended sleep-away camp? Yes No - If yes, where, when and for how long?

Describe the applicant's ability to travel independently.

Does the applicant have a driver's license? Yes No - If yes, does the applicant have his/her own car? Yes No

Describe the assistance and supports the applicant may need in terms of independent living skills (e.g. cooking, shopping, budgeting, cleaning and travel).

Safety skills: Circle all categories that applicant is aware of regarding safety

Fire Safety, Use of telephone, Use/storage of chemicals, regulation of temperature,
Use of appliances, sharing personal information, no admittance of strangers in home

Describe the applicant's social skills

Have there been any behavioral or emotional difficulties with family, peers or others? Yes No – If yes, please describe

Has the applicant ever been arrested? Yes No – If yes, describe the charges and the outcome of the arrest.

In efforts to best evaluate and support the applicant, JEVS expects the applicant, family, and /or referring organization to provide complete and accurate information. Therefore, by signing below you are verifying that the information contained within this application is accurate and complete to the best of your knowledge. If it is determined that applicable information was not disclosed in this application or any part of the application process, the applicant may be deemed ineligible for admission. If it is determined once the applicant has been accepted or admitted into the program that information known by the applicant, family member(s) or referring organization or individual was not disclosed, the participant may be dismissed from the program and there will be no refunds!

Signature of applicant: _____ Date: _____

Signature of parent: _____ Date: _____

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