The Arc
Central Chesapeake Region

The Arc Central Chesapeake Region's Mission Statement

The Arc Central Chesapeake Region promotes respect, creates opportunities and advocates for equal rights for all people with intellectual and developmental disabilities.

By working with each family and their loved ones, we strive to minimize challenges and obstacles in their lives by focusing on their strengths, abilities and inherent value. Through our programs, services and advocacy, The Arc seeks to help individuals with developmental and intellectual disabilities live fulfilling, independent and productive lives, contribute to their community and fully participate in the world around them.

The Arc Central Chesapeake Region's Core Values

People First. The Arc believes that all people with intellectual/developmental disabilities have strengths, abilities and inherent value; are equal before the law; and must be treated with dignity and respect.

Democracy. A democratic process involving members, through affiliated chapters, is utilized to take positions on important issues, policies and programs.

Visionary Leadership. The Arc leads by promoting the mission, core values and position statements. We lead with integrity, accountability, and by open, honest, and timely communication.

Community Participation. The Arc works toward and believes in the community imperative: that all people have the fundamental moral, civil and constitutional rights to live, learn, work, play and worship in safe and healthy communities of their choosing.

Diversity. The Arc values and insists upon diversity in its leadership and membership. The Arc actively pursues and welcomes diverse groups (including but not limited to race, ethnicity, religion, age, geographic location, sexual orientation, gender and level of disability).

Integrity and Excellence. The Arc conducts its business with integrity. The Arc reflects quality and excellence in all its work.

Achieve with us.

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Admission Procedure

1. A referral from an individual, family and/or service agency comes into the office and it is forwarded to admissions@thearcccr.org.

2. An admission letter and application packet will be sent to the individual.

3. Once the application has been received at The Arc Central Chesapeake Region office a letter of acknowledgement will be sent out.

4. The completed packet is reviewed by The Arc Central Chesapeake Region Admissions Committee. This committee will make an initial determination of whether or not the applicant's service needs can be addressed.

5. You will be contacted within one week regarding this committee's decision.

6. If the committee's initial determination is that the individual's service needs can be addressed, then you will be contacted to continue the application procedure.

7. If the committee's determination is that the individual's service needs cannot be addressed, then the application packet will be returned.

8. If the committee's determination is that the individual's service needs can be addressed, then the individual and/or family will be contacted so that the Service Funding Plan (SFP) can be developed.

9. An individual meeting will be scheduled with the individual to review and sign the Service Funding Plan and to go over The Arc Central Chesapeake Region's Individual Rights and Contribution to Care.

10. Once the SFP is finalized by the Individual's team, the SFP will be submitted to Developmental Disabilities Administration (DDA) for approval.

Note: The length of the approval of an SFP will be determined by the availability of funds through DDA.
The Arc has no control over this process.

1332 Donald Avenue, Severn, MD 21144
Phone: 410-269-1883 Fax: 410-384-4015

8626 Brooks Drive #306, Easton, MD 21601
Phone: 410-269-1883 Fax: 410-384-4015

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Application for Services

(Please Print or Type)

Date of Application: _____

Check program(s) for which application is being submitted:

___ Supported Employment ___ Residential

___ Family Support Services ___ Individual Support Services

___ Community Day ___ Personal Supports

___ Shared Living (Individual Family Care)

Applicant's General Information:

Name:_____
Last First Middle

Address: _____
Street City State Zip Number of Years

Phone #: _____ E-mail Address: _____

Date of Birth: _____ Place of Birth: _____
Month / Day / Year City State

Social Security Number: _____ Type of Income/Amount: _____

Medicaid/Medical Assistance Number: _____ Other: _____

Does Applicant have a Resource Coordinator: _____
Name Phone Number

Parent/Guardian/Caregiver Information:

Name: _____ Relationship to Applicant: _____

Address: _____

City and State: _____

Phone #: _____ E-mail Address: _____

Applicant's Living Situation/Family Information:

___ Parents ___ Guardian or Relatives ___ Another Provider

___ Other

Name: _____

Address: _____ Phone Number: _____

Does the applicant have a Legal Guardian? ____ Yes ____ No

If yes, please list name, address, phone # and e-mail address of this person: _____
_____
_____

Date Guardianship was attained: _____

Type of Guardianship (check whichever is applicable):

___ Full ___ Property ___ Limited ___ Medical

Does the applicant have a Surrogate Decision Maker? ____ Yes ____ No

If yes, please list name, address, phone # and e-mail address of this person: _____
_____
_____

Does the applicant have an Advance Directive? ____ Yes ____ No

If yes, please list name, address, phone # and e-mail address of their Health Care Agent: _____
_____
_____

Parent Information:

Father's Mother's (Maiden)

Name: _____ Name: _____

Birthdate: _____ Birthdate: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Occupation: _____ Occupation: _____

Work Phone: _____ Work Phone: _____

Work Address: _____ Work Address: _____

Social Security: _____ Social Security: _____

Living/Deceased -- if deceased, give date: _____

Living/Deceased -- if deceased, give date: _____

Place of Birth: _____ Place of Birth: _____

Marital Status: _____ Marital Status: _____

Brothers and Sisters:

Name	Birthdate	Address	Phone Number	Occupation

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone Number: _____

Applicant's Financial Information:

SSI Claim Number: _____ SSI Amount: _____

SSA Claim Number: _____ SSA Amount: _____

Name of Wage Earner: _____

SSDI Claim Number: _____ SSDI Amount: _____

Name of Representative Payee (if different from applicant): _____

V.A. Claim Number: _____ VA Amount: _____

Name of Veteran: _____

Railroad Retirement Claim Number: _____ Railroad Retirement Account: _____

Name of Wage Earner: _____

Life Insurance Coverage (Please include a copy.):
_____

Name, Address, Phone # and e-mail address for Life Insurance Beneficiary: _____
_____
_____

Burial Plot Location: _____ Estimated Value: _____

Type of Burial Plan (Please include a copy.): _____

Other Sources of Applicant Income: _____

Applicant's Bank Account Number: _____ Bank Name: _____

Any Property in Applicant's Name (give location and value): _____

Does the applicant have a Trust Fund (Please include a copy.)?: ___ Yes ___ No

If yes, type: _____

Name, address and phone # of Trustee: _____
_____

Applicant's place of employment (name and address): _____
_____

Applicant's monthly earnings from employment: _____

Medical Information:

A. Applicant's Primary Health Care Provider/Physician: _____

Address: _____ Phone Number: _____

Date of Last Physical Exam: _____ Examined By: _____

Hospital Familiar with Applicant: _____

B. Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

C. Diagnosis

Primary: _____

Secondary: _____

Tertiary: _____

Age of Onset: _____

D. List any medication (s) taken by Applicant

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

E. Seizures

1. Does the applicant have seizures? ___ Yes ___ No
2. Frequency? ___ Daily ___ Weekly ___ At Least Once a Month

   ___ Every Few Months ___ Other (please specify): _____
3. Type of Seizure: _____
3. Are seizures controlled by medication? ___ Yes ___ No

F. Applicant's Mobility

___ Walks Independently ___ Uses Cane ___ Uses Walker ___ Uses Crutches

___ Uses Wheelchair ___ Manual ___ Electric

G. Vision

1. Any vision impairment? ___ Yes ___No
2. Does applicant wear glasses or contact lenses? ___ Yes ___ No
3. Date of last eye examination: _____ Legally Blind? ___ Yes ___ No

H. Hearing

1. Does the applicant have a hearing problem? ___ Yes ___ No Explain: _____
2. Does the applicant wear a hearing aid? ___ Yes ___ No
3. Date of last hearing examination: _____Deaf? ___ Yes ___ No

I. Dental

1. Date of last dental examination: _____ Dentures? ___ Yes ___ No

2. Brief description of any dental problems: _____

J. Speech and Language Information

1. Does the applicant have any speech/language impairment? ___ Yes ___ No

2. Is the applicant verbal? ___ Yes ___ No

3. Has the applicant had speech/language assessment? ___ Yes ___ No

4. If yes, assessment done by: _____

5. Means of communication: ___ Speech ___ Sign Language ___ Gestures

___ Communication Board ___ Other

K. Allergies (bee stings, drugs, dust, mold, food, etc.): _____
_____

L. Does the applicant have any other medical problems not listed above? _____
_____

M. Does the applicant have a history of alcohol or substance abuse? ___ Yes ___ No

List previous treatment and dates: _____
_____

N. Has the applicant ever been convicted of a crime? ___ Yes ___ No

Provide details: _____

_____

_____

O. Is any other family member diagnosed as having a disability? ___ Yes ___ No

Describe: _____

_____

_____

P. Is there any other Family Medical Background not listed above? (example: cancer, heart disease, genetic syndrome, etc.) _____

Psychological Information:

A. Date of last psychological evaluation: _____

1. Performed by: _____

2. Address: _____

3. Diagnosis: _____

B. Has the applicant received any mental health services? (i.e. counseling, out-patient or in-patient services) ___ Yes ___ No

Describe: _____
_____
_____
_____

C. Does the applicant have a history of behavioral problems? ___ Yes ___ No
(if yes, describe the problem using the chart below)

Behavior Problem	Frequency	Severity	Intervention

Does the applicant have a behavior plan? ___ Yes ___ No

Background Information:

Name of School(s)	Complete Address	Dates Attended

Contact Person: _____

Adult Program(s)	Complete Address	Dates Attended

Contact Person: _____

Vocational Training or Evaluation Complete Address Dates Attended

_____
_____
_____
_____
_____

Contact Person: _____

Skills Checklist:

A. Is the applicant independent in personal self-care skill? ___ Yes ___ No

B. Can the applicant self medicate? ___ Yes ___ No

C. Can the applicant cross streets? ___ Independently ___ With assistance ___ No

D. Can the applicant use mass transit? ___ Independently ___ With assistance ___ No

E. Can the applicant remain at home unsupervised? ___ No ___ Yes, how long _____

F. Can the applicant read? ___ No ___ Yes, level _____

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Signature of Applicant (if at least 18 years old) Date

_____ _____
Signature of Person Completing the Form Date

The Arc Central Chesapeake Region, Inc provides services and operates it facilities without discrimination on the basis of race, color, national origin, religion, political affiliation, marital status, age, sex or disability. The following information is useful for statistical purposes only. Completion of this portion of the application is voluntary.

Religion: _____

Ethnic Identification (check as applicable): ___ Black ___ Caucasian ___ Hispanic

___ Asian ___ Native American ___ Other

U.S. Citizen? ___ Yes ___ No

Sex: ___ Male ___ Female

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Language(s) spoken or understood: ___ English ___ Other, specify _____

Language(s) used in applicant's home environment: ___ English ___ Other, specify _____

For Office Use Only

Critical Needs List: ___ Yes ___ No

If yes, check level of services approved: ___ Residential ___ Supported Employment ___ ISS

___ FSS ___ CSLA

Crisis Resolution: _____

Crisis Prevention: _____

Current Request: _____

Waiting List Initiative: _____

Waiting List Equity: _____

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Authorization to Release/Obtain Information:

Date: _____

Individuals Name: _____ D.O.B.: _____

Address: _____

_____

I, _____, hereby authorize Developmental Disabilities Administration (DDA), Service Coordination and _____ to release medical, psychological, social narrative and other pertinent information to The Arc Central Chesapeake Region, Inc. as presently requested by same. Authorization is extended for this request only and at this time only.

I understand that the information is requested for the purpose of assisting The Arc Central Chesapeake Region in serving me now and/or planning with me for the future. I understand that all information will be treated in a strictly confidential manner.

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian (if client is under 18) Date

_____ _____
Witness (must sign if "X" is used) Date

_____ _____
Agency Representative Date