Your Choice Counseling, LLC| YCFC
Empowering Kids & Teens, Wherever They Are!
✨ Community-Based Day Services for Ages 3–19✨

Application for Services

☐ **Community Engagement**

A. Processing Information (this section to be filled out by YCFC staff)

	DATE	INITIALS
1. Screening/Referral Received	_____	_____
2. Follow-up Contact/Schedule Tour	_____	_____
3. Tour Date.	_____	_____
4. Application/Intake Packet Received	_____	_____
5. Intake Meeting	_____	_____
6. Start Date	_____	_____

B. General Information of Service Applicant

1. Applicant's Name: _____ Service(s) Applying for:

☐ Community Engagement

2. Present Address: _____

3. Permanent Address: _____

4. Home Telephone: _____ 5. Day Telephone: _____

6. Date and Place of Birth: _____ 7. Gender: ☐Male ☐Female

8. Social Security Number: _____ 9. Citizenship Status: _____

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10. Marital Status: _____ 11. Legal Status: _____

12. Language spoken and/or understood: _____

13. Religious Preference: _____

* Provision of this information is voluntary. YCFC does not discriminate against applicants because of race, sex, creed, religion, or national origin.

14. Medical Insurance (company/Policy Number) or Medical Assistance.

(Type/Number): _____ (Type/Number): _____

(Type/Number): _____ (Type/Number): _____

C. Identification Information

1. Height: _____ 2. Weight: _____ 3. Eye Color: _____
4. Hair Color: _____ 5. Identifying Marks: _____
6. Recent Photograph (please attach):

D. Family/Guardian Information

1. Parent(s) Name(s) or Next-of-kin (if parent(s) are deceased)
   a. Name: _____
   b. Address: _____
   c. Telephone Number: _____
   d. Nature of Relationship: _____

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E. Emergency/Other Contact

1. Physician
   a. Name: _____
   b. Address: _____
   c. Telephone Number: _____

2. CSB Support Coordinator (if assigned): _____ Phone Number: _____

F. Program Information

Living Arrangement:

☐ Lives with Family (Home Address provided above)

☐ Residential Provider:

Provider Name: _____

Address: _____

Program Manager Name: _____

Contact Number: _____

Email: _____

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1. Educational Background (list present or last attended school.

Attach separate page for other schooling.

   a. School: _____

   b. Address: _____

   c. Phone Number: _____

   d. Diploma/highest grade completed: _____

2. Therapeutic Consultation Provider:

   a. Provider Name: _____

   b. Address: _____

   c. Phone Number: _____

   d. Therapeutic Consultation Specialist: _____

☐ Behavioral Plan Attached ☐ Behavioral Plan will be submitted on: _____

3. PT/OT/RT/Speech Therapy Providers:

   a. Provider Name: _____

   b. Address: _____

   c. Phone Number: _____

   d. Therapeutic Consultation Specialist: _____

☐ Plan Attached ☐Plan will be submitted on: _____

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G. Individual Support Information

1. Medical, Behavioral and Social condition(s) resulting in need for support:

   Diagnoses:

   Behavioral Conditions:

   Social Support Needs:

   1) Major Limitations/Restrictions to daily activities:

   2) Use of adaptive/Equipment (wheelchair, walker, etc.):

H. Medical Status/History

1) Description of general health:

2) Date of Last Physical (physician/date):

3) Current Medications (prescription and nonprescription, type, dosage, frequency, condition being treated, method of administration, Note “None” if appropriate).

4) Allergies (note “None” if appropriate)

5) Recent Physical Complaints

6) Serious Illnesses and chronic conditions of individual’s parents and siblings, if known

7) Past serious illnesses, infectious diseases, serious injuries, and hospitalizations

8) Substance abuse history, if applicable

I. Sexual Health and Reproductive History

a. List and describe any past/present sexual health issues.

b. Does the service applicant have any children? ☐ Yes ☐No

If yes, List name(s), age(s), address(s), and contact frequency and issues:

J. Independent/Personal Living Skills

a. Self-help (grooming, dressing, bathing, feeding, toileting)

b. Communication (strengths and support needs)

c. Household (cleaning, cooking, laundry)

d. Leisure (interest, activities, hobbies)

e. Mobility (if you use cane, or wheelchair, please note)

f. Behavioral (list strengths and support needs)

g. Community (shopping, banking, use of public transportation)

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K. Financial Information

1. Representative Payee for Benefits: _____

2. Income/Assets
   a. Does the individual receive SSI? ☐Yes ☐No
   b. Other source of income (please specify nature and value)

L. Personal Information

1. Why do you want/need to receive services? Specify exact needs.

2. How soon do you need services? (If immediately, please specify a reason).

3. When, where, and how would you like us to contact you?

_____ _____

Signature and title/position of Person(s) filing out Date