ComServ, Inc. Application for Services

☐ Residential	☐ Day Services	☐ AFL	☐ Other:	Date

Applicant Information:			
Name:		SS#:	
Birth Date:	Record #	Age:	Sex:
Medicaid #:		Medicaid County:	
Medicare #:	Dates of Coverage	Medicare Carrier:	
Address (Current Location):			

Family Dynamics	
Father's Information:	**Mother's Information:**
Name:	Name:
Address:	Address:
Phone:	Phone:
Cell:	Cell:
E-mail:	E-mail:

Other Significant Persons:		
Name:	**Age:**	**Relationship:**

Referred By:	
Name:	Agency:
Address:	
Phone:	
Fax:	
E-mail:	

Guardian Information:	
Does Individual have a guardian assigned? ☐ Yes ☐ No	Relationship:
Name:	Address:
Phone:	E-mail:

Financial Information:	
Does the individual receive SSI? ☐ Yes ☐ No	
Does the individual have Medicaid? ☐ Yes ☐ No	
Does the individual have Medicare? ☐ Yes ☐ No	
Does the individual have private insurance? ☐ Yes ☐ No	
Does the individual have Innovations? ☐ Yes ☐ No	**Care Coordinator Name/Phone:**
Other:	

Medical Information:		
Diagnosis (Please List)		
If individual is taking any medications please list below:		
Medication:	Dosage:	Reason:
Please list any and all known allergies:		
Please explain any physical and/or medical issues the individual may have:		
Present Height:	Present Weight:	BMI: (Optional)
Physician:	Phone Number:	Date of Last Physical:
Dentist:	Phone Number:	Date of Last Appointment:
Specialist:	Phone Number:	Date of Last Appointment:
Specialist:	Phone Number:	Date of Last Appointment:
Specialist:	Phone Number:	Date of Last Appointment:

Please list any hospitalizations:			
Placement:	Admission:	Discharge:	Reason:

Habilitative Information:		
Does individual have seizures?	□ Yes □ No	
Does individual require a special diet?	□ Yes □ No	Explain: If yes, requires a Dr. order.
Does individual eat independently?	□ Yes □ No	If no, please explain support.
Does individual require any adaptive equipment?	□ Yes □ No	If yes, please explain support.
Is there a history of choking?	□ Yes □ No	
Does individual toilet independently?	□ Yes □ No	If no, please explain support.
Does individual wear diapers/pull ups?	□ Yes □ No	If yes, please indicate size.
Can individual communicate wants and needs?	□ Yes □ No	If no, what is indication?
Does individual sleep through the night?	□ Yes □ No	Please list sleep time and wake time.
Is individual ambulatory?	□ Yes □ No	If no, please indicate type of mobility.
Is individual verbal?	□ Yes □ No	Please explain any communication needs or equipment.

Does individual have a history of any of the following?
__ physical aggression __ verbal aggression __ property destruction __ self-injurious behavior __ inappropriate sexual behavior ___ Tantrumming __ AWOL __ PICA
Please explain in detail about the individual's inappropriate behaviors (please include triggers, times, and/or any other important information concerning these behaviors).
Please tell us what the individual likes and dislikes.
Likes:
Dislikes:

In order to determine if ComServ, Inc. is the best provider for services we ask that you complete this application entirely and attach the following information for review;

- Psychological Evaluations
- IEP, if applicable
- Medical History
- Service Plan (IPP, PCP, ISP, etc.)

Any other pertinent information regarding the individual that may assist our team in determining appropriateness for placement.

By my signature below, I am giving permission for this application and all attached information to be shared with ComServ, Inc.

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Signature of Individual/Legally Responsible Person Date