



# Application for Services

VODEC Office Use:

	Completed Application Received

Please complete the application. In addition, please forward other documents that may be useful in helping us understand your strengths and areas of support needed. Examples may include social history, current ICP/IEP, and behavioral supports plan. Once all documents have been received, we will review each document for admission. Admission is subject to vacancy, approval, funding, and other eligibility requirements. All notifications of decisions regarding services will be communicated to you via telephone or in writing. It is our policy to be an Affirmative Action Equal Opportunity Employer for all qualified applicants for employment without regard to race, color, religion, sex, age, national origin, or disability.

\_\_\_\_\_  
Applicant or Legal Representative Signature

\_\_\_\_\_  
Date

Applicant's Information				
Name	Street	City	State	Zip
Phone	Best time to call?	Date of Birth	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female
Cell Phone		Social Security Number		
	Medicaid Number			
Services Requested:		How did you hear about Vodec?		
<input type="checkbox"/> Day Hab <input type="checkbox"/> Supported Employment <input type="checkbox"/> Employment Training (Pre-Voc/Pre-Employment) <input type="checkbox"/> Residential (including HH/EFH)				
Applicant's Primary Disability (Check one)		Funding Source (Check One)		
<input type="checkbox"/> Autism		<input type="checkbox"/> ID Waiver		
<input type="checkbox"/> Asperger's Syndrome		<input type="checkbox"/> BI Waiver		
<input type="checkbox"/> Behavior Disorder		<input type="checkbox"/> Hab Services		
<input type="checkbox"/> Blind		<input type="checkbox"/> Private Pay		
<input type="checkbox"/> Brain Injury		<input type="checkbox"/> School Pay		
<input type="checkbox"/> Chronic Mental Illness		<input type="checkbox"/> Voc Rehab Pay		
<input type="checkbox"/> Deaf/Hard of Hearing		<input type="checkbox"/> Other:		
<input type="checkbox"/> Down Syndrome				
<input type="checkbox"/> Intellectual Disability				
<input type="checkbox"/> Physical Disability		For Habilitation Services, list the corresponding diagnosis code:		
<input type="checkbox"/> Other:				

**Contact information**

<b>Contact Information</b>	<b>Case Manager/Service Coordinator Name</b>
	<b>Case Manager/Service Coordinator Company</b>
	Mailing Address
	Primary Phone
	Secondary Phone
	Fax
	Type of Service(s) provided: <span style="float: right;">___ Current ___ Previous</span>
	Date of Service from:
	Date of Service to:
	<b>Legal Guardian's Name</b>
	Mailing Address
	Primary Phone
	Secondary Phone
	<b>Is Legal Guardian an emergency contact for this individual?</b> ___ Yes ___ No
	<b>Conservator's Name</b>
	Mailing Address
	Primary Phone
	Secondary Phone
	<b>Is Conservator an emergency contact for this individual?</b> ___ Yes ___ No
<b>Power of Attorney's Name</b>	
Mailing Address	
Primary Phone	
Secondary Phone	
<b>Is Power of Attorney an emergency contact for this individual?</b> ___ Yes ___ No	
<b>Payee's Name</b>	
Mailing Address	
Primary Phone	
Secondary Phone	
<b>Is Payee an emergency contact for this individual?</b> ___ Yes ___ No	
<b>Additional Contacts If Applicable</b>	<b>Voc Rehab Counselor's Name</b>
	Mailing Address
	Primary Phone
	Secondary Phone
	<b>Teacher's Name</b>
	Mailing Address
	Primary Phone
Secondary Phone	