Community Based Solutions, LLC
1157 South Military Highway Suite 104, Chesapeake Virginia 23320
Office (757)523-6379
Email: communitybasedsolutions@gmail.com

APPLICATION FOR SERVICES

Sponsor Residential_____ Group Home Residential ____ Day Program______

Name: ________________________________ Address: ______________________________________

Phone: ____________ DOB:_____________ Gender: Male / Female Status: Married/ Single / Divorced

SS#_______________ Medicaid #_______________ Medicare #____________________

Diagnosis: ID:________________MH:______________________ Other: _________________________

CSB:_________________________________ Case Manager: _______________________________

Phone:___________________________ Extension:__________ Fax:______________________

Funding Source (s)____

Guardian _________________ Address:_____________________________ Phone:____________________

Authorized Representative:____

Address:____ Phone: __________________

Emergency Contact: _______________________________________ Phone: __________________

Current Situation & Previous Services:____

____

____

Description of needs (include communication, mobility, social, etc.)_____________________________________

____

____

____

Reason for referral: ____

____

Previously authorized waiver hours: Residential:__________ Day Support:____________________

In-Home:___________ Therapeutic Consult:_________ Specialized Supervision: _____________

Current Income (SSI, SSA, co-pay, etc.):____

Present Payee: ______________________________________ Phone: __________________

Prepared by:____ Date:____________________

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EMERGENCY MEDICAL INFORMATION AND RELEASE FOR EMERGENCY TREATMENT

Name:______________________________________ SSN:________________________________

Address: ____

Phone: ______________________________ Date of Birth: ______________________________

Residential Contact:___________________________ Phone#: ______________________________

Medicaid #: _________________________________ 2nd Insurance: _________________________

Physician/Phone & Address: ____

Emergency Contact: ____

Relationship: _______________________________ Phone: ______________________________

Medical Conditions Affecting Treatment: ____

____

____

Allergies: ____

Adverse reactions to medications: ____

Current Medications: ____

____

____

Substance Abuse History: ____

Communication Disorders:____

Advanced Directive: YES NO If yes, contacts: ____________________________________

I hereby authorize associates employed by Community Based Solutions, LLC to seek, obtain medical treatment and transport me in the event of a medical emergency. This release will expire upon my oral or written request, or upon my discharge from the program.

______________________________ ______________________________

Individual's Signature & Date Residential Manager Signature & Date

____

Guardian/Authorized Representative Signature & Date

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INDIVIDUAL HEALTH HISTORY

Name: ____ Medicaid # ______________________________

Allergies: _____________________________________ Seizures: ________________________________

Recent physical complaints and medical conditions:____

____

Chronic conditions (including communication barriers): ____

____

____

Communicable diseases: ____

____

Handicaps/restrictions on physical activities or mobility, if any: ____

____

____

Past serious illnesses, serious injuries and hospitalizations:____

____

Illnesses and chronic conditions of this individual's parents, siblings and significant others in the same house: ____

____

____

Current and past drug usage (to include alcohol, prescription and non-prescription or illicit drugs): _____________

____

Sexual health/reproductive history: ____

____

Current Primary Care Physician: __________________________ Phone: ___________________________

Address:____

Other physicians, psychiatrist, specialists etc. ____

____

Prepared by:____ Date:______________________

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INDIVIDUAL SOCIAL HISTORY

Name: ____ Medicaid # ______________________

Mother's Name: ____________________________________ Date of Birth: ____________________

Address: ____ Phone:__________________________

Father's Name: _______________________________ Date of Birth: __________________________

Address: ____ Phone: __________________________

List any living relatives and their relationship:____

____

List any long-term friends:____

____

Previous living arrangements: ____

____

Behavioral/Emotional Concerns: ____

____

____

Social strengths / needs: ____

____

Educational History: (include the name of schools and estimate dates of attendance) ____________________

____

____

Employment History: (include the name of employer, type of work and estimate dates of hire) _____________

____

____

Additional Comments:____

____

Prepared by:_______________________________________ Date:___________________________