My Life My Way

Application Packet

Section 1: General Information
Section 2: Financial
Section 3: General Medical/Health
Section 4: Authorization to Release Information Form

Mail your completed application with a non-refundable
$50 application fee payable to Hattie Larlham to:

Shelly Benson
1402 Boettler Road, Suite B
Uniontown, Ohio 44685
330-931-7360

My Life My Way

Section 1: General Information

General Information

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ / _____ / ___ M ____ F ____

Current School or Employer: _____

Currently Lives With: _____ Phone Number: _____

Guardian Name(s): _____

Referred By: _____

E-Mail: _____

Family Status

Mother's Name: _____ Father's Name: _____

Stepmother's Name: _____ Stepfather's Name: _____

Siblings Name(s):

_____

_____

Emergency Numbers

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City: _____ State: ___ ZIP: _____ City: _____ State: ___ ZIP: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone:_____

1. Why would you like to come to My Life My Way?

_____
_____
_____
_____

2. What goals do you want to reach in one year?

_____
_____
_____
_____

3. What goals do you want to reach in five years?

_____
_____
_____
_____

4. What schooling or training have you completed?

_____
_____
_____
_____

5. What kind of work have you done or jobs have you held? (Please fill in the box)

Employer	Job Title	Dates of Employment
1		
2		
3		
4		
5		

6. Which job did you enjoy the most and why?

_____
_____
_____
_____
_____
_____

7. Have you participated in any other kind of social or independent living program? When and where?

_____
_____

8. What medications do you take and what are they for? Are you able to administer your medication independently?

_____
_____
_____

9. Have you had any medical issue we should be aware of?

_____
_____
_____

10. What do you feel are your strengths?

_____
_____
_____

11. What do you feel are your challenges?

_____
_____
_____

12. Who helps you the most with your problems?

_____
_____
_____

13. Who are your best friends?

_____
_____
_____

14. What questions or concerns do you have about My Life My Way?

_____
_____
_____

My Life My Way staff has my permission to communicate with my family and my current or former doctors or other health care professionals regarding my health status and me.

Signature: _____ Date: _____

My Life My Way does not discriminate on the basis of race, religion, color, national origin or gender

Parent or Guardian Information

1. Why are you interested in the services of My Life My Way for your child or ward?

_____
_____
_____
_____
_____

2. What are your immediate goals (over the next 1-2 years) for your child or ward?

_____
_____
_____
_____
_____

3. What are your long-term goals (over the next 5 years) for your child or ward?

_____
_____
_____

_____
_____
_____

4. Briefly describe in your own words, your child's or ward's strengths and challenges.

_____
_____
_____
_____
_____
_____

5. What are your greatest concerns about your child's or ward's participation in My Life My Way?

_____
_____
_____
_____
_____
_____

Parent or Guardian Signature: _____ Date: _____

My Life My Way

Section 2: Financial Information

As parent(s)/guardian(s) of _____, (I/we) promise that (I/we) will:
(the member applicant)

1. Personally pay in full to My Life My Way any payments or amounts not covered by the member.

Other payment arrangements (please describe):_____
_____

Contact Person: _____ Phone: _____

2. Be financially responsible for all other debts incurred by the member while involved with My Life My Way including any expenses not covered by insurance.

Signature of Parent or Guardian: _____ Date: _____

Address: _____

Home Phone: _____ Business Phone: _____

E-Mail Address: _____

Do you have a Waiver or other state or county support that will be beneficial for this program?

_____
_____
_____

My Life My Way

Section 3: Health History Information

Applicant's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Birth Date: _____

Allergies

Drug(s):_____
_____

Environmental: _____
_____

Food(s):_____
_____
_____

Seizure Disorder: _____
_____
_____
_____

Current Diagnosis: _____
_____
_____
_____
_____
_____
_____
_____

Social Substances History:

Substance Used? Yes/ No For How Long? Not Used Since

Alcohol: _____

Tobacco: _____

Other: _____

Current Medications (Rx and OTC)

Medication	Dosage	Frequency	Purpose	How Long?

Self-Care / Activities of Daily Living

Hearing Loss: _____ Yes _____ No

Vision Correction: _____ Yes _____ No

Assistive Device: _____

_____

_____

Active Regular Exercise: _____

_____

_____

Mobility Status: _____

_____

_____

Self-Care Assistance: _____

_____

_____

_____

Sleep Problems: _____

_____

_____

_____

Psychosocial History

Please give a description of your client's developmental disability and/or mental illness: _____
_____
_____
_____
_____
_____

Current living situation. What are your independent living goals and options?
_____
_____
_____
_____

Academic Achievement Level: _____
_____
_____
_____
_____

Physician Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Business Phone: _____ Cell Phone: _____

Other medical or health care professionals providing service to this client:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Signature: _____ Date: _____

My Life My Way

Section 4: Authorization to Release Information Form

Client Name: _____
Social Security Number: _____ Date of Birth: _____
I authorize My Life My Way and its professional staff to:

_____ Release To
_____ Receive From
_____ Telephone Exchange With
_____ Other _____

_____ Medical Information
_____ Psychological Test Reports
_____ Psychiatric/Psychological Information

Records or other information NOT to be released: _____
_____
_____
_____

Name and Title: _____
Facility: _____
Address: _____
City: _____ State: _____ ZIP: _____

This authorization shall expire 120 days from the date of the signing and is subject to revocation by the client at any time prior to the expiration date, but not made retroactive to any information already released. I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release.

Client Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____