APPLICATION FOR ADDITIONAL SERVICES

Date of Application: ____________________

Applicant name: ____________________

Address: ____________________ Zip ________

Phone: ____________________ Is applicant their own guardian? ________

Parent / Guardian Name: ____________________

Phone: (home) ____________(work) ____________ (cell) ____________

Please check the services desired from Candeo:

Intellectual Disability ______ SCL/DAILY ______ SCL/HRLY ______ SE

Habilitation ______ SCL/DAILY ______ SCL/HRLY ______ SE _____ WRAP

Brain Injury ______ SCL/DAILY ______ SCL/HRLY ______ SE _____ WRAP

Walgreens REDI ______

Identifying Goals/Need for Services: ____________________

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FINANCIAL

Current benefits (list amount received each month)

SSI ________ SSDI ______ Food Stamps ________ TANF _____ Other _____

Have you received past benefits that are now terminated? ____________________

Would you like benefits planning education? ____________________

REFERRAL

Referral Source/Case Manager: ____________________

Email: ____________________Phone:____________________

Funding Source for HBH/SE WRAP: ____________________

Funding Source for SCL: ____________________

Funding Source for HBH: ____________________

Funding Source for SE: ____________________