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 _______ Employment

Habilitation _______ SCL/DAILY _ SCL/HRLY _______ Employment

Brain Injury _______ SCL/DAILY _ SCL/HRLY ______ Employment

Employment Service (please specify)

_______ Career Exploration ____Discovery ____Job Coaching ____Job Development

Identify Goals/Need for Services: ______________________________________

____

FINANCIAL

Current benefits (list amount received each month)

SSI ______ SSDI ________ Food Stamps _______ TANF _____

Housing Assistance (section 8) _____ Veteran Benefits _____ Worker's Comp _____

Other ____

Have you received past benefits that are now terminated? __________________________

Would you like benefits planning education? ______________________________

REFERRAL

Referral Source/Case Manager: ______________________________________

Email: ______________________Phone:______________________

Medicaid MCO: ______ Amerigroup ______ United

Funding Source for SCL: ______________________ Tier ______________

Funding Source for HBH: ______________________ Tier ______________

Funding Source for SE: ______________________________________

Do you have an open case with Voc. Rehab (IVRS)? Yes ____ No ____

Assigned IVRS Counselor and Contact information: ______________________________