Kent Center

Providing Opportunities for Adults with Developmental Disabilities

APPLICATION FOR SERVICES

Today's Date: _____

Name: _____ Date of Birth: _____

Current Address: _____

City:_____State:_____Zip:_____

Place of Birth:_____ Social Security Number:_____

Telephone number:_____ Additional Telephone Number:_____

Person completing this Application_____
(if different from applicant) (Printed) (Signature)

Referred by:_____

Person to contact in case of emergency:

Name: _____Relationship_____

Address: _____Telephone(s)_____

Services

What services are requested at this time: Day, Residential, Supported Employment, Individual Support, Other:
_____

Reason for referral or applying to Kent Center:

_____

_____

_____

_____

215 Scheeler Road * Chestertown * Maryland * 21620 * (410) 778-7303 * (410) 778-7305 Fax
www.kentcenter.org

DISABILITY AND MEDICAL INFORMATION

Diagnosis: Primary: _____

Secondary: _____

Other: _____

How old were you when your disability was initially diagnosed?_____

What medications, if any, do you take?_____

_____

_____

Do you need someone to administer medications to you? Yes No

Do you require medication by injection? Yes No
If yes, specify medication _____

Do you have difficulty swallowing medication? Yes No

Do you have seizures? Yes No
What type:_____How often_____
Date of last seizure:_____Neurologist:_____

Do you have any other medical conditions, problems or issues that we should know about? Yes No
Please specify: _____

_____

_____

_____

_____

Do you have allergies? Yes No Specify:_____

_____

Do you have any prostheses or invasive devices? Yes No
Specify: _____

_____

Primary Physician and/or Health Facility providing Medical Care:

Name: _____Telephone:_____

Address_____

City: _____State:_____Zip:_____

Date Last Seen:_____

Specialist: (if applicable)

Name: _____Telephone:_____

Address: _____

City: _____State:_____Zip:_____

Date Last Seen: _____

Additional Specialist: (if applicable)

Name: _____Telephone:_____

Address:_____

City: _____State:_____Zip:_____

Date Last Seen:_____

Dental care provided by:

Name:_____Telephone:_____

Address:_____

City:_____State:_____Zip:_____

Have you received Hepatitis B inoculations? Yes No Type:_____

Dates:_____,_____,_____ Specify month and year for each.

PERSONAL INFORMATION

Sex:_____ Height:_____ Weight:_____ Race_____ Marital Status:_____

Color of Hair:_____ Color of Eyes:_____ Indentifying Marks:_____

Language Spoken or Understood:_____

Language(s) used at home:_____

Sign Language: Fluent: _____ Understand Some:_____ None:_____

Has legal competence been determined?_____

Do you have a legal guardian?_____If yes, who:_____

Name of Court/Judge:_____Date of Judgment:_____

Guardian's Address & Phone:_____
_____County:_____

FINANCIAL INFORMATION

Please check all sources of financial support that you receive:
____Work income
____Supplemental Security Income (SSI)
____Other Social Security Benefits
____Pension Benefits
____Family Support

INSURANCE INFORMATION

Medical Assistance Number (Medicaid): _____
Medicare Number: _____
Private Insurance Company: _____
Type and Policy Number: _____
Military Benefits or Insurance: _____
Type and Policy Number: _____

Kent Center

Providing Opportunities for Adults with Developmental Disabilities

Authorization to Release Information

Individuals Name: _____

Individuals Birthdate: _____

Individuals Address: _____

_____

This is to authorize the release of information from Kent Center, Inc to any health, education, private or public agency or person who may be providing services to or on behalf of above names of individual.

The purpose of releasing this information to other agencies and or persons, is to assist in providing complete and appropriate services.

This authorization shall be valid for the period of one year with the date it is signed.

Information to be released: (Indicated with an "X")

___ Medical Information

___ Financials

___ Person Centered Plan

___ Camera Release

___ Lease

___ Goal Data Collection

___ Other (Specify) _____

Information indicated may only be releases to the following agency or person:

_____

_____

_____

_____

_____
Legal Guardian or Witness

_____
Individuals Signature

_____
Relationship to Individual

_____
Date Signed

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Kent Center, Inc.

Providing Opportunities for Adults with Developmental Disabilities

Publicity/Photo/Video Authorization Form

&

Disclosure

I hereby authorize and give consent to Kent Center, Inc., to interview/photograph/video tape me and to utilize any photographs, motion picture, slides and written or oral comments in one or more of the following media: employee or community publications; fundraising campaign publicity; advertising; brochures or information materials for the public internet pages; public news media (radio, television, newspapers). There are also marked areas in the Day Program that are under 24hr surveillance.

Name_____

Address_____City_____State/Zip_____

Phone# Day_____Evening_____

I waive any proprietary rights in ownership of any material used in any capacity, consign to the release of material, and agree to hold harmless Kent Center, Inc. from any claims that I have which may arise from use.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on it. Any requests for revocation must be in writing and sent to Kent Center, Inc., or any of its affiliates, if applicable. This authorization will expire in ten (10) years from this date. If the publication is in the form of a brochure that will be circulated for several years, the expiration date shall be the date of the publication's archival.

I certify that I have read, understood, and agree to the terms set forth in this authorization.

Your signature_____Date____/____/____

If you are signing as a Personal Representative or Guardian for the above subject, you may be asked to provide proof of your identity and your authority to sign for the individual. Please fill out and sign below:

Your name_____

Your relationship to the individual_____

Your signature_____Date___/___/____

Witnessed by:_____

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