

A NEW LEAF, INC.  
Certified Family Home  
Application for Services



Date: \_\_\_\_\_

Personal Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mailing (If Different): \_\_\_\_\_

Major intersections near home: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Medicaid#: \_\_\_\_\_

Targeted Service Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

Parents: \_\_\_\_\_ Phone: \_\_\_\_\_

Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (If different.): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Living Situation: \_\_\_\_\_

Please List Current ResHab Agencies/Therapies: \_\_\_\_\_

Please List Any Past ResHab Agencies/Therapies: \_\_\_\_\_

Professionals:

Physician:	Phone:
Specialist:	Phone:
Counselor:	Phone:
Dentist:	Phone:
Optometrist:	Phone:
Audiologist:	Phone:
Other:	Phone:
Other:	Phone:

Medical Information:

Primary Diagnosis: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Seizure Disorder: YES/NO Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Known Allergies/Special Diet: \_\_\_\_\_

Assistive Devices: \_\_\_\_\_

Communicable Disease: YES/NO If Yes, What? \_\_\_\_\_

Please list any other medical concerns: \_\_\_\_\_

Behavioral Information:

Please check any current behaviors:

Verbally Assaultive	Stealing	Screaming
Physically Assaultive	PICA	Obsessive/Compulsive
Self-Injurious	Property Destruction	Defiance
Lying	Sexual Misconduct	Other:

Please check any past behaviors:

Verbally Assaultive	Stealing	Screaming
Physically Assaultive	PICA	Obsessive/Compulsive
Self-Injurious	Property Destruction	Defiance
Lying	Sexual Misconduct	Other:

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Requested Start Date: \_\_\_\_\_

Please give a short description of your major areas of concern, goals, and potential outcomes you would like to see through Certified Family Home services:

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Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_