

The Arc of the Central Chesapeake Region's Mission Statement

The Arc of the Central Chesapeake Region advocates for the rights and respect of all people with intellectual and developmental disabilities by providing resources and inspiring community awareness and action.

The Arc of the Central Chesapeake Region's Core Values

People First. The Arc believes that all people with intellectual and developmental disabilities have strengths, abilities and inherent value; are equal before the law; and must be treated with dignity and respect.

Democracy. A democratic process involving members, through affiliated chapters, is utilized to take positions on important issues, policies and programs.

Visionary Leadership. The Arc leads by promoting the mission, core values and position statements. We lead with integrity, accountability, and by open, honest, and timely communication.

Community Participation. The Arc works toward and believes in the community imperative: that all people have the fundamental moral, civil and constitutional rights to live, learn, work, play and worship in safe and healthy communities of their choosing.

Diversity. The Arc values and insists upon diversity in its leadership and membership. The Arc actively pursues and welcomes diverse groups (including but not limited to race, ethnicity, religion, age, geographic location, sexual orientation, gender and level of disability).

Integrity and Excellence. The Arc conducts its business with integrity. The Arc reflects quality and excellence in all its work.

The Arc of the Central Chesapeake Region

931 Spa Road

Annapolis, MD 21401

Phone: 410-269-1883

Fax: 410-269-0091

Admission Procedure

1. A referral from an individual, family and/or service agency comes into the office and it is forwarded to Jessica Dicus, Coordinator for Program Services.
2. Jessica Dicus will send admission letter and application packet to individual.
3. Once the application has been received at The Arc of the Central Chesapeake Region office a letter of acknowledgement will be sent out.
4. The completed packet is reviewed by The Arc of the Central Chesapeake Region Admissions Committee. This committee will make an initial determination of whether or not the applicant's service needs can be addressed.
5. You will be contacted within one week regarding this committee's decision.
6. If the committee's initial determination is that the individual's service needs can be addressed, then you will be contacted to continue the application procedure.
7. If the committee's determination is that the individual's service needs cannot be addressed, then the application packet will be returned.
8. If the committee's determination is that the individual's service needs can be addressed, then the individual and/or family will be contacted so that the Individual Service Plan can be developed.
9. An individual meeting will be scheduled with the individual to review and sign the Individual Service Plan (ISP) and to go over The Arc of the Central Chesapeake Region's Support Agreement and Contribution to Care.
10. Once the ISP is finalized by the Individual's team, the ISP will be submitted to Developmental Disabilities Administration (DDA) for approval.

Please Note: The length of the approval of an ISP will be determined by the availability of funds through DDA. The Arc is not involved in and can not influence this process.

Applicant's Living Situation/Family Information (include names):

___ Parents: _____

___ Guardian or Relatives: _____

___ Foster Home: _____

___ Other: _____

Address: _____ Phone Number: _____

Does the applicant have a Legal Guardian? ___ Yes ___ No

If yes, please list name, address, phone # and e-mail address of this person: _____

Date Guardianship was attained: _____

Type of Guardianship (check whichever is applicable): ___ Full ___ Property
___ Limited ___ Medical

Does the applicant have a Surrogate Decision Maker? ___ Yes ___ No

If yes, please list name, address, phone # and e-mail address of this person: _____

Does the applicant have an Advance Directive? ___ Yes ___ No

If yes, please list name, address, phone # and e-mail address of their Health Care Agent: _____

Parent Information:

Father's

Mother's (Maiden)

Name: _____ Name: _____

Birthdate: _____ Birthdate: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Occupation: _____ Occupation: _____

Work Phone: _____ Work Phone: _____

Work Address: _____ Work Address: _____

Social Security: _____ Social Security: _____

Living/Deceased -- if deceased, give date: _____ Living/Deceased -- if deceased, give date: _____

Place of Birth: _____ Place of Birth: _____

Marital Status: _____ Marital Status: _____

Brothers and Sisters:

Name	Birthdate	Address	Phone Number	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone Number: _____

Applicant's Financial Information:

SSI Claim Number: _____ SSI Amount: _____

SSA Claim Number: _____ SSA Amount: _____

Name of Wage Earner: _____

SSDI Claim Number: _____ SSDI Amount: _____

Name of Representative Payee (if different from applicant): _____

V.A. Claim Number: _____ VA Amount: _____

Name of Veteran: _____

Railroad Retirement Claim Number: _____ Railroad Retirement Account: _____

Name of Wage Earner: _____

Life Insurance Coverage: _____

Name, Address, Phone # and e-mail address for Life Insurance Beneficiary: _____

Burial Plot Location: _____ Estimated Value: _____

Type of Burial Plan: _____

Other Sources of Applicant Income: _____

Applicant's Bank Account Number: _____ Bank Name: _____

Any Property in Applicant's Name (give location and value): _____

Does the applicant have a Trust Fund?: Yes No

If yes, type: _____

Name, address and phone # of Trustee: _____

Applicant's place of employment (name and address): _____

Applicant's monthly earnings from employment: _____

Medical Information:

A. Applicant's Primary Health Care Provider/Physician: _____

Address: _____ Phone Number: _____

Date of Last Physical Exam: _____ Examined By: _____

Hospital Familiar with Applicant: _____

B. Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

Specialist Doctors: _____

Address: _____ Phone Number: _____

Date of Last Visit: _____ Reason: _____

C. Diagnosis

Primary: _____

Secondary: _____

Tertiary: _____

Age of Onset: _____

D. List any medication (s) taken by Applicant

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

Medication: _____

Dosage: _____ Reason: _____

E. Seizures

1. Does the applicant have seizures? Yes No

2. Frequency? Daily Weekly At Least Once a Month
 Every Few Months Other (please specify): _____

3. Type of Seizure: _____

3. Are seizures controlled by medication? Yes No

F. Applicant's Mobility

Walks Independently Uses Cane Uses Walker Uses Crutches

Uses Wheelchair Manual Electric

G. Vision

1. Any vision impairment? Yes No

2. Does applicant wear glasses or contact lenses? Yes No

3. Date of last eye examination: _____ Legally Blind? ___ Yes ___ No

H. Hearing

1. Does the applicant have a hearing problem? ___ Yes ___ No Explain: _____

2. Does the applicant wear a hearing aid? ___ Yes ___ No

3. Date of last hearing examination: _____ Deaf? ___ Yes ___ No

I. Dental

1. Date of last dental examination: _____ Dentures? ___ Yes ___ No

2. Brief description of any dental problems: _____

J. Speech and Language Information

1. Does the applicant have any speech/language impairment? ___ Yes ___ No

2. Is the applicant verbal? ___ Yes ___ No

3. Has the applicant had speech/language assessment? ___ Yes ___ No

4. If yes, assessment done by: _____

5. Means of communication: ___ Speech ___ Sign Language ___ Gestures
___ Communication Board ___ Other

K. Allergies (bee stings, drugs, dust, mold, food, etc.): _____

L. Does the applicant have any other medical problems not listed above?

M. Does the applicant have a history of alcohol or substance abuse? ___ Yes ___ No

List previous treatment and dates: _____

N. Has the applicant ever been convicted of a crime? ___ Yes ___ No

Provide details: _____

O. Is any other family member diagnosed as having a disability? ___ Yes ___ No

Describe: _____

P. Is there any other Family Medical Background not listed above? (example: cancer, heart disease, genetic syndrome, etc.) _____

Psychological Information:

A. Date of last psychological evaluation: _____

1. Performed by: _____

2. Address: _____

3. Diagnosis: _____

B. Has the applicant received any mental health services? (i.e. counseling, out-patient or in-patient services) ___ Yes ___ No

Describe: _____

C. Does the applicant have a history of behavioral problems? ___ Yes ___ No
(if yes, describe the problem using the chart below)

Behavior Problem	Frequency	Severity	Intervention

Does the applicant have a behavior plan? ___ Yes ___ No

Background Information:

Name of School(s)	Complete Address	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contact Person: _____

Adult Program(s)	Complete Address	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contact Person: _____

Vocational Training or Evaluation	Complete Address	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contact Person: _____

Skills Checklist:

- A. Is the applicant independent in personal self-care skill? ___ Yes ___ No
- B. Can the applicant self medicate? ___ Yes ___ No
- C. Can the applicant cross streets? ___ Independently ___ With assistance ___ No
- D. Can the applicant use mass transit? ___ Independently ___ With assistance ___ No
- E. Can the applicant remain at home unsupervised? ___ No ___ Yes, how long _____
- F. Can the applicant read? ___ No ___ Yes, level _____

For Office Use Only

Critical Needs List: Yes No

If yes, check level of services approved: Residential Supported Employment ISS
 FSS CSLA

Crisis Resolution: _____

Crisis Prevention: _____

Current Request: _____

Waiting List Initiative: _____

Waiting List Equity: _____

Authorization to Release/Obtain Information:

Date: _____

Individuals Name: _____ D.O.B.: _____

Address: _____

I, _____, hereby authorize _____

To release medical, psychological, social narrative and other pertinent information to The Arc of the Central Chesapeake Region, Inc. as presently requested by same. Authorization is extended for this request only and at this time only.

I understand that the information is requested for the purpose of assisting The Arc of the Central Chesapeake Region in serving me now and/or planning with me for the future. I understand that all information will be treated in a strictly confidential manner.

Signature

Date

Signature of Parent or Guardian (if client is under 18)

Date

Witness (must sign if "X" is used)

Date

Agency Representative

Date