APPLICATION FOR SERVICES

David E. Puryear Center
P.O. Box 16622
Jonesboro, AR 72403
Phone: 870-932-0200

AGENCY USE ONLY
Date App Received_____
Date Preadmission Meeting_____

NAME_____

HOME ADDRESS_____

HOME PHONE_____BUSINESS PHONE_____

BIRTHDATE_____BIRTHPLACE_____

SOCIAL SECURITY NO._____MEDICAID NO._____

NAME & ADDRESS OF PARENT(S) _____

_____

_____

SINGLE_____MARRIED_____DIVORCED_____

LIST THE NAME(S) & ADDRESS OF THE LEGAL GUARDIAN.
LIST THE DATE AND COURT THE GUARDIANSHIP WAS ESTABLISHED.

_____

_____

_____

MAJOR DISABILITIES:

Mental Retardation____ Epilepsy____ Cerebral Palsy____ Down's Syndrome_____
Deaf_____ Blind_____ Mental Illness_____

INDICATE THE SERVICES WHICH HAVE BEEN RECEIVED OR
ARE NOW BEING RECEIVED:

_____Social Services (Welfare)
_____Children's Medical Services
_____Special Education
_____Regular School Classes
_____Sheltered Workshop
_____Day Service Center
_____Residential Services
_____Mental Health Center
_____Rehabilitation Services
_____Nursing Home
_____Other (Specify)

(Please use back of this page to give details of any above services that were received or are now being received; i.e. include place, dates, type of service, etc.)

Give a brief description of the applicant to include physical description
(Include recent photo if possible), personality characteristics, behavior problems,
strengths and needs, and any other pertinent information.

_____

_____

_____

_____

Give brief description of the applicant's family to include names, ages, and occupation of parents, siblings and other immediate family members.

_____

_____

_____

_____

List any family members or friends who have received services or who have been employed at the David E. Puryear Center.

_____

_____

_____

List any information regarding Psychological or Psychiatric Evaluations
(Include any test scores, test dates and any diagnoses).

_____

_____

_____

_____

Give a brief report of the education and vocational training which the applicant has received, including dates, places and types of training:

_____

_____

_____

_____

List any special medical care, medication, special diets, special equipment needs or physical restrictions which the applicant requires:

_____

_____

Applicant's Height: _____

Applicant's Weight: _____

Is he/she now being treated for a medical condition? Yes_____No_____
If yes, please describe below.
_____

_____

Give date of last visit to the following:
Medical Doctor: _____Date:_____

Dentist: _____Date:_____

Optometrist: _____Date:_____

Orthopedist: _____Date:_____

Physical Therapist: _____Date:_____

Psychologist: _____Date:_____

Neurologist: _____Date:_____

Is the applicant ambulatory? Yes_____ No_____
Is the applicant in general good health? Good_____Fair_____Poor_____
Is applicant in good dental health? Good_____Fair_____Poor_____

Does he/she have hospitalization insurance? _____
If so, give company and policy number:_____

_____

Does applicant receive SSI_____ If yes, what amount per month $_____

Does the applicant receive Social Security? _____
If yes, what amount per month $_____

What financial resources does the applicant now have?
_____

Does the applicant have a checking or savings account? _____
If so, what type of account (please list balances) _____

_____

Does he/she have outstanding financial obligations?
_____

My signature below attests to the fact that the applicant's parent/guardian/advocate are in agreement with this application to the David E. Puryear Center and will work with the staff to help the applicant attain his/her goals in life here at the Center.

_____

Parent/Guardian/Advocate ***Date***

_____

Client ***Date***

_____

Witness ***Date***