Diversified OPPORTUNITIES, INC.

Application for Services

1. **Identifying Information**

Name: _____

Address: _____

_____ County: _____

Email Address: _____

DOB: _____ Phone: _____

Insurance Provider Name and Number (Medicaid, Medicaid, etc.): _____

_____

2. **Disability** – Please attach Psychological, Comprehensive Clinical Assessment, etc. to support disability

Primary Disability: _____

Secondary Disability: _____

Other: _____

3. **History**

A. Medical History

Current Medications and Dosage: _____

_____

_____

_____

Able to administer own medication: ☐Yes ☐No

Allergies: _____

Physical Limitations: _____

Do you require any work adaptations or accommodations: _____

_____

Medical Provider/Physician: _____

B. Educational History

School: _____

Highest Grade Achieved: _____ Year: _____

C. Vocational History

Are you interested in pursuing employment in the community? □Yes □No

If yes, do you have a current case open with Vocational Rehabilitation? □Yes □No

Work History: (Include any prior employment, vocational training, etc.) _____

_____

D. Social History

Financial Support: (Family, SSI, SSDI, VA, Food Stamps): _____

Legal Guardian: □Yes □No If yes, Name: _____

Emergency Contact Name: _____ Phone: _____

Address: _____

_____

E. Additional Comments

_____

_____

_____

_____

_____

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4. Transportation

Transportation to and from Day Program Provided by: _____

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5. Required Items at Your First Meeting

__ Psychological
__ Mental Health Records
__ Guardian Certificate (if applicable)
__ List of Current Medications

Signature: _____ Date: _____