PLEASE RETURN TO: Kathy Edwards
Chimes, Inc.
4814 Seton Drive
Baltimore, MD 21215

APPLICATION

(*Please print or type*)

[*Check program(s) for which application is being submitted*]

☐ School ☐ Day Habilitation ☐ Vocational Services ☐ Residential Services ☐ Support Services

Applicant's Name: ______________________________
Last First Middle Called By

Current Residence: ______________________________
Street City State Zip Code # of Years

Legal Residence: ______________________________
Street City State Zip Code # of Years

Lives With (Check Applicable): ☐ Parents ☐ Legal Guardian ☐ Provider Home ☐ Foster Home ☐ Other__________

Date of Birth: ______________ Place of Birth: ______________ U.S. Citizen: ☐ Yes ☐ No
Month Day Year City and State

Sex: ________ Height: ______ Weight: ________ Eye Color: ________ Hair Color: __________

Identifying Marks: ______________________________

Language(s) Spoken or Understood: ☐ English ☐ Other (Specify):__________

Language(s) Used In Applicant's Home: ☐ English ☐ Other (Specify):__________

Applicant's Marital Status:______________ Applicant's Social Security #: ______________

****PLEASE INCLUDE COPY OF BIRTH CERTIFICATE AND SOCIAL SECURITY CARD****

Referred By:

Name: ______________________

Address: ______________________

City/State: ______________________

Relationship to Applicant:______________________

Legal Guardian:

Name: ______________________

Address: ______________________

City/State: ______________________

Telephone No.:______________________

Email Address: ______________________

Relationship to Applicant: ______________________

Date Guardianship Obtained: ______________________

Type of Guardianship [*Check applicable*]:

☐ Person ☐ Property ☐ Both

****PLEASE ATTACH COPY OF GUARDIANSHIP DOCUMENT ****

Applicant's Name:________________________________

[*Complete the following*]

Father's Name:______________________ Date of Birth:______________________

Address: ______________________ Personal Email Address:______________________

Home Phone:______________________ Cell Phone:______________________

Father's Occupation:______________________ Business Phone:______________________

Business Address:______________________ Business Email Address:______________________

Retired? ☐ Yes ☐ No Date:______________ Deceased? ☐ Yes ☐ No Date:______________

Mother's Name:______________________ Date of Birth:______________________

Address:______________________ Personal Email Address:______________________

Home Phone:______________________ Cell Phone:______________________

Mother's Occupation:______________________ Business Phone:______________________

Business Address:______________________ Business Email Address:______________________

Retired? ☐ Yes ☐ No Date:______________ Deceased? ☐ Yes ☐ No Date:______________

Brothers and Sisters [*Use Back of Application for Additional Names*]:

Name:______________________ Date of Birth: ______________________

Address:______________________ Phone: ______________________

Occupation:______________________ Email Address:______________________

Name:______________________ Date of Birth: ______________________

Address:______________________ Phone: ______________________

Occupation:______________________ Email Address:______________________

Benefit information

Name of Current Representative Payee:______________________________________

Address: ______________________________________

Phone Number: ______________ Cell Phone: __________ Email Address: ______________

Applicant's Medicaid/Medical Assistance Number: ______________________________

Name of Applicant's HMO: ______________________ ID #: ______________________

Applicant's Medicare #: ______________________ Part(s): ☐ A ☐ B ☐ D

Name of Prescription Plan: ______________________ ID #: ______________________

Other Medical Insurance:

Name: ______________________ ID#: ______________________

Name: ______________________ ID #:______________________

Applicant's Name:____________________

Applicant's SSI Claim #:____________________ SSI Monthly Benefit:____________________

Applicant's SS Claim #:____________________ SS Monthly Benefit:____________________

SSDI Claim #:____________________ SSDI Monthly Benefit:____________________

Name of Wage Earner:____________________

V.A. Claim #:____________________ V.A. Monthly Benefit:____________________

Name of Veteran:____________________

Railroad Retirement Claim #:____________________ RR Monthly Benefit:____________________

Other Sources of Applicant's Income:____________________

Life Insurance Policy Name:____________________ ID #:____________________

Burial Plot? ☐ Yes ☐ No If yes, location: ____________________

Pre-Paid Burial Plan? ☐ Yes ☐ No Name of Funeral Home:____________________

Burial Account Name of Bank:____________________ Account #:____________________

Applicant's Community Bank Accounts:

Name of Bank:____________________ Acct #:____________________Balance:____________________

Name of Bank:____________________ Acct #:____________________Balance:____________________

Trust Fund? ☐ Yes ☐ No If yes, name and address of attorney:____________________

____

Property in Applicant's Name: ☐ Yes ☐ No If yes, address of property:____________________

____

Personal Information

Applicant's Primary Care Practitioner: ____________________

Address: ____________________ Phone #: ____________________

Date of Applicant's Last Physical Exam: ____________________

Medical Facility Familiar with Applicant: ____________________

Address: ____________________ Phone #: ____________________

Diagnoses:

Primary: ____________________

Secondary: ____________________

Tertiary: ____________________

Applicant's Age at Onset of Disability? ____________________

Applicant's Name:________________________________

List All Allergies (Bee Stings, Drugs, Dust, Mold, Etc.): ____

____

____

Requires Immediate Access to EPI-Pen? ☐ **Yes** ☐ **No**

Mobility (check applicable):

Independent:______ With Physical Assistance:______ Cane:______ Walker: ______ Manual Wheelchair:______

Electric Wheelchair:______

Vision:

Visual Impairment? ☐ Yes ☐ No Wears Glasses? ☐ Yes ☐ No Date of Last Exam: ____________________________

Hearing:

Hearing Impairment? ☐ Yes ☐ No Wears Hearing Aid? ☐ Yes ☐ No Date of Last Exam: __________________________

Dental :

Edentulous? ☐ Yes ☐ No Wears Dentures? ☐ Yes ☐ No Date of Last Dental Exam: ____________________________

Toileting:

Independent? ☐ Yes ☐ No Needs Assistance? ☐ Yes ☐ No Incontinent? ☐ Yes ☐ No

Eating:

Independent? ☐ Yes ☐ No Needs Assistance? ☐ Yes ☐ No G-Tube? ☐ Yes ☐ No Food By Mouth? ☐ Yes ☐ No

Medications: Able to Self-Medicate? ☐ Yes ☐ No

Bathing:

Independent? ☐ Yes ☐ No Needs Assistance? ☐ Yes ☐ No Needs Adaptive Equipment? ☐ Yes ☐ No

Can Control Water Temperature? ☐ Yes ☐ No

Activity Preferences (Please list in order of importance): ____

____

____

____

SCHOOL /PROGRAM INFORMATION

Name of School(s) attended:	Complete Address	Dates Attended
______________________	______________________________________	__________
______________________	______________________________________	__________
______________________	______________________________________	__________
______________________	______________________________________	__________

Applicant's Name:________________________________

Adult Program(s) attended:

______________________________ ____ _____________

______________________________ ____ _____________

______________________________ ____ _____________

______________________________ ____ _____________

Vocational Training or Evaluation:

______________________________ ____ _____________

______________________________ ____ _____________

______________________________ ____ _____________

______________________________ ____ _____________

Signature of Parent/Guardian (If Applicant):____ Date:__________

Signature of Applicant (If over 18 years old):____ Date:__________

Signature of Person Completing Form:____ Date:__________

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For Office Use Only:

Date Application Received: ____________________________

Funding Intent Confirmed With DDA: ☐ Yes ☐ No

Applicant's Name:______________________________

Chimes does not discriminate in the provision of services to persons served and is an equal opportunity employer as stipulated in Chimes Policy on Non-Discrimination.

The following information is optional.

Religion: ________________________________

Ethnic Identification:

________ Hispanic

________ Asian

________ American Indian

________ Indian

________ African

________ African American

________ Caucasian

________ Bi-Racial

________ Other