|  |  |
| --- | --- |
| Client Name: |  |
| Client Email: |  |
| Client Phone # |  |
| Name of person applying for: |  | DOB: |  |
| Primary Diagnosis: |  |
| Secondary Diagnosis: |  |
| IQ, if known: |  |
| Additional information about the disability (describe the individual’s life skills, for example dress without any reminders? Cooking? Set own alarm? Showering: need help or reminders? Knows what to wear from weather?) |
|   |
| Do you have guardianship? |  |
| Does the individual have Medicaid? |  |
| Are either of the parents receiving an SSA benefit or are they deceased? |  |
| Briefly describe the individual’s work history: |  |
| Briefly describe the support you are looking for: |  |

|  |  |
| --- | --- |
|  |  |
| **Income:**  | **Assets: (value if applicable)** |
| **Child Support (Court Ordered):** |  | **Bank Account:** |  |
| **Average gross monthly income:** |  | **UTMAs/529s:** |  |
| **SSDI or other benefits:****Whose record:** |  | **Savings Bonds:** |  |
| **Other:** |  | **Credit Cards:** |  |
| **Total:** |  | **Total:** |  |
|  |
| **Trusts:** | **Funded:** | **How much:** |
| **Typical Trust** |  |  |  |
| **Special Needs Trust** |  |  |  |
| **Self-Funded (payback) Trust** |  |  |  |
| **Other:** |  |  |  |