KENOSHA ACHIEVEMENT CENTER, INC.
Application for Services

PLEASE PRINT OR TYPE: Fill in the entire form as completely as possible. The information provided is confidential and is needed to provide KAC with a basis of assisting you in determining appropriate program needs.

Name: _____
Last First Middle

Address: _____
Street City/State Zip

Telephone: _____ Email Address: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female

I am my own guardian ❑ Yes ❑ No

If no: Name: _____ Phone: _____

Who is available to help you if you need it?

Name: _____ Phone Number: _____

Current Living Situation:
❑ Rent ❑ Group Home ❑ Adult Family Home ❑ Halfway House
❑ Own Home ❑ Homeless With whom do you live?
❑ Live with Family ❑ Other _____ Name: _____
Phone Number: _____

Are you:
❑ Single Spouse's Name: _____
❑ Divorced
❑ Separated Residence: _____
❑ Married
❑ Widowed Phone Number: _____

Expectations/Goals for KAC Program and Employment in general: _____

_____

What are your interests/hobbies for free time? _____

FINANCIAL

Do you receive:		Amount		Amount
	❑ SS/SSI/SSDI	_____	❑ Veteran's Benefits	_____
	❑ IRIS	_____	❑ Pension	_____
	❑ MCO/Family Care	_____	❑ Child Support	_____
	❑ W2/TANF	_____	❑ Spousal Support	_____
	❑ Food Share	_____	❑ Earnings from Employment	_____
			❑ Other _____	_____

Do you have a Social Security application pending? ❑ Yes ❑ No

Do you have medical insurance?

❑ Forward Card ❑ Through employment ❑ Parents ❑ Private Pay

MEDICAL

What is your medical/disabling condition(s)? _____

What caused your condition? _____

When did your condition start? _____

Who diagnosed your condition? _____

Have you had any severe injuries? ❑ Yes ❑ No

If yes, please describe: _____

Have you had any severe diseases? ❑ Yes ❑ No

If yes, please describe: _____

Are you currently taking medication? ❑ Yes ❑ No

Who administers medication? _____

Any problems/limitations in these areas, please describe and when onset:

Speech ❑ Yes ❑ No If yes, please describe: _____

Vision ❑ Yes ❑ No If yes, please describe: _____

Hearing ❑ Yes ❑ No If yes, please describe: _____

Physical ❑ Yes ❑ No If yes, please describe: _____

Do you have seizures? ❑ Yes ❑ No How frequently? _____

❑ grand mal ❑ petti mal ❑ other

Do you have an awareness of seizure before occurrence? ❑ Yes ❑ No What? _____

Are there outwardly identifiable signs before occurrence? ❑ Yes ❑ No What? _____

History of Hospital or Institutional Care:

FACILITY	YEAR/LENGTH OF STAY	REASON

Is assistance needed to complete activities of daily living? If so, please explain in detail:

PHYSICAL ACTIVITY	WHAT KIND OF ASSISTANCE OR EQUIPMENT IS NEEDED?
Sitting	
Standing	
Moving from one seat to another	
Toileting/Personal Hygiene	
Getting to and from the floor	
Walking or Wheeled Mobility (wheelchair, scooter)	

Other Accommodations/Needs: _____

Please identify if you are or have been involved with any of the following agencies or services:

- ❑ WI DVR (Div. Of Voc. Rehab.)
- ❑ CSP (Community Support Program)
- ❑ AODA Treatment
- ❑ CRISIS Services
- ❑ CIC (Community Intervention Center)
- ❑ MCO/Family Care/IRIS
- ❑ Probation & Parole
- ❑ Other _____

SCHOOL

NAME	DATES ATTENDED	DEGREE YES/NO

TRANSPORTATION

Do you have a license? ❑ Yes ❑ No
Do you have a car? ❑ Yes ❑ No
Do you use the city bus? ❑ Yes ❑ No
Do you use specialized transportation? ❑ Yes ❑ No What? _____
Do you have other transportation? ❑ Yes ❑ No What? _____

How far are you willing to travel for employment? _____

EMPLOYMENT

Have you ever been employed? ❑ Yes ❑ No

History of Employment – Include Armed Services

EMPLOYER	JOB TITLE	DATES	REASON FOR LEAVING

Is job searching difficult? ❑ Yes ❑ No If yes, why? _____

Is keeping a job difficult? ❑ Yes ❑ No If yes, why? _____

AUTHORIZATION: I certify that my responses to this application have been made freely, voluntarily and without coercion and that information given is accurate to the best of my knowledge. As applicable, I understand that my records are protected under federal regulations governing confidentiality and cannot be released without appropriate written consent.

_____

Signature of Applicant Date Guardian (if applicable) Date

Did you receive assistance with this application? ❑ Yes ❑ No

If so, who? _____