



**New Horizons Supported Services, Inc.**  
**16000 Trade Zone Ave. # 109**  
**Upper Marlboro, MD 20774**  
**301)-249-0206/Fax (301)-249-4512**

### **Service Application**

**Thank you for your interest in our program. In order to expedite this referral process, all of the attached information must be provided or the application will be considered incomplete. This process is critical for assessing the needs of prospective Individuals and determining their current needs. After completion of this application, please return it to the Director of Program Services at the above address. We do accept faxed copies but ask that the original completed application be returned to us.**

**The following forms are included in this Packet:**

- Service Application – Must be completed, signed and dated by the applicant/referral source.**
- Authorization for release of information**
- Physical Form**
- Dental Form**

**Once again, thank you for your interest in New Horizons Supported Services, Inc. We look forward to hearing from you. Please feel free to contact us (301) 249-0206 if you have any further questions.**



## NEW HORIZONS SUPPORTED SERVICES INC. APPLICATION FOR SERVICES

The applicant and the referring agency must complete this application. Please place N/A by any information that is not applicable. **All lines must be filled in or the application will be considered incomplete.** All information will remain confidential.

### Referral

Source: \_\_\_\_\_

### Documents that must accompany this application:

1. Current Eligibility Letter from DDA
2. Current Psychological (within the last year)
3. Current Dental examination
4. Current Physical

I.

**Services Requested:**  Vocational (Day) Training  Employment Services  
 Individual Support Services (ISS)  
 Community Supported Living Arrangement(CSLA)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Are you 21 years of age: yes \_\_\_ no \_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Emergency  
Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Phone(H) \_\_\_\_\_

\_\_\_\_\_ Phone(W) \_\_\_\_\_

**Parents/Caregiver Information**

Name/Caregiver: \_\_\_\_\_ Phone:(H) \_\_\_\_\_

Address: \_\_\_\_\_ Phone:(W) \_\_\_\_\_

\_\_\_\_\_ Cell: \_\_\_\_\_

**Legal Competency Status:** Please check

Legal Guardian: \_\_\_\_\_ Self \_\_\_\_\_ Other – Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_

\_\_\_\_\_ Phone (W) \_\_\_\_\_

**II. Entitlements and Insurance Information**

Have you been deemed eligible for DDA funding: \_\_\_yes \_\_\_no \_\_\_unsure

Please specify source of income if applicable. Please check one or more of the following:

\_\_\_ SSI - \$ \_\_\_\_\_

\_\_\_ SSDI - \$ \_\_\_\_\_

\_\_\_ SSA - \$ \_\_\_\_\_

\_\_\_ Employment - \$ \_\_\_\_\_

\_\_\_ Other – Please specify \_\_\_\_\_ \$ \_\_\_\_\_

Insurance Carrier:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Current

Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

III.

**Personal Information**

Hair Color: \_\_\_\_\_ Eye Color \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender: \_\_\_ Male \_\_\_ Female

Identifying Marks (be specific) \_\_\_\_\_

Adaptive Equipment Need: Any adaptive equipment needed “**must have a doctor’s order**”

Walker  Wheelchair  Brace  Crutches  Hearing Aid  Cain

Other: \_\_\_\_\_

**Independent Task**

Feeds Self: \_\_\_\_\_ yes \_\_\_\_\_ no Toilets Self: \_\_\_\_\_ yes \_\_\_\_\_ no

Speech: \_\_\_ Verbal or \_\_\_ Non-Verbal \_\_\_ Other \_\_\_\_\_

**Behaviors** – (please list any behavior(s) that may require a behavior plan)

Describe:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

**Educational history**

Last School attended: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

Received: \_\_\_\_\_ Certificate \_\_\_\_\_ Diploma \_\_\_\_\_ Did not complete

Able to: \_\_\_\_\_ read \_\_\_\_\_ write

IV.

**Health History**

Primary Disability: \_\_\_\_\_

Secondary Disability; \_\_\_\_\_

Current Medications: \_\_\_\_\_ (If not on medication write N/A)

Medication - _____	Dose _____	Frequency _____
_____	Dose _____	Frequency _____
_____	Dose _____	Frequency _____
_____	Dose _____	Frequency _____

Please provide the following information:

Serious illnesses: \_\_\_\_\_

Injuries: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Hospitalizations (within last 2years):

Hospital: \_\_\_\_\_ Date(s) \_\_\_\_\_ to \_\_\_\_\_

Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospital: \_\_\_\_\_ Date(s) \_\_\_\_\_ to \_\_\_\_\_

Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Childhood diseases (please check):  Chicken pox  Measles  Mumps

Tuberculosis  Other (explain) \_\_\_\_\_

Seizure: (please check)  yes  no

Last Seizure: (give date) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of last Dental Exam: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

I agree to provide and/or release information pertinent to the services I am requesting. This may include but is not limited to, vocational, educational, medical, and psychological records.

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Applicants Signature

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Date

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Parent/Guardian/Caregiver Signature

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Date

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Witness Signature

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Date

**Return completed Application to:  
Attention to: Director of Program Services**

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