



119 Tunnel Road Suite 120  
Asheville, NC 28805  
Telephone (828) 254-9917  
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**RESIDENTIAL SERVICES APPLICATION**

Date: \_\_\_\_\_ MCO ID: \_\_\_\_\_

Which services are you interested in?

\_\_\_ Alternative Family Living \_\_\_ Residential Services \_\_\_ Apartment Living

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Number, Street, Route, Box City State Zip County

Phone No.: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Medicare ID: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_ SS# \_\_\_\_\_

Private Ins.Co. \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Managed Care Organization: \_\_\_\_\_ Care Coordinator: \_\_\_\_\_

Contact Person: \_\_\_\_\_  
Name

Address: \_\_\_\_\_  
Number, Street, Route, Box City State Zip County

Phone No.: \_\_\_\_\_  
Home Work

Relationship:  Parent  Legally Responsible Person  Guardian

Other: \_\_\_\_\_ Type Guardianship: \_\_\_\_\_

Date of Adjudication: \_\_\_\_\_ County of Adjudication: \_\_\_\_\_

Name of Guardian: \_\_\_\_\_  
Last First Middle

Guardian's Address: \_\_\_\_\_  
Number, St., Route, Box City State Zip Country

Guardian's Phone Number: \_\_\_\_\_  
Home Work

**DIAGNOSIS – DSM III-R** (complete all that apply, or attach a recent psychological evaluation):

AXIS I \_\_\_\_\_

AXIS II \_\_\_\_\_

AXIS III \_\_\_\_\_

Last Psychological Evaluation \_\_\_\_\_ Date: \_\_\_\_\_

Referral Source and Contact Number: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

**Current Residential Arrangement:**

- Private Home
- DDA Group Home
- Rest Home
- ICF/MR Bed
- Respite
- Other
- Family Care Home
- State Inst. (non-ICF/MR)

Dates Admitted: \_\_\_\_\_ Dates Discharged: \_\_\_\_\_

Program Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Current Services (or attach a copy of the current Individual Service Plan):**

- School
- ADVP
- Supported Employment
- Comp. Ed.
- Residential
- Day Supports
- Personal Care
- Developmental Therapy
- Respite
- None

**Former Services (include any ICF/MR, Nursing Facility Placement):**

Residential:	Date:	From:	To:

**Please describe the daily support needs and wants of this person:**

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**What is important to this person about where he or she lives (e.g., does she prefer privacy? Quiet? A small space)?**

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**What is important to this person (e.g., what people, places, things does he enjoy)?**

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**What is important for the person (e.g., any health and safety concerns)?**

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**Has this person experienced a crisis in the past? If yes, please describe it and how it was managed:**

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**Applicant Signature**

**Date**

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**Parent/Guardian Signature**

**Date**

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**Care Coordinator Signature**

**Date**

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**LCE Staff Signature**

**Date**