CONSUMER APPLICATION

Share Your Heart | Independent Living Center

Date: _____

Consumer Name: _____ Parent/Caregiver: _____

Address: _____ City/State: _____ Zip Code: _____

Contact #:_____ Email: _____ County:_____

When contacting me by phone, you MAY speak to anyone who might answer the phone:_____

When contacting me by phone, you MAY leave a message on the system? _____

Date of Birth: _____ Age: _____ Gender: _____ Ethnicity: _____

Primary Disability**:** _____ Secondary: _____ Veteran: Yes ☐ No ☐

Referred by: _____ Service Requested: _____

Your disability is: *(Check all that apply)*

☐ Cognitive ☐ Mental/Emotional ☐ Physical ☐ Hearing ☐ Vision ☐ Multiple Disabilities

Are you currently on an IEP/WAIVER: ☐ Yes ☐ No

If Yes, please list type of Waiver: _____

Do you feel you are at risk of being placed in a facility/institution? ☐ Yes ☐ No

Do you need information in an adaptive format, an interpreter, or language translator? ☐ Yes ☐ No

Do you want to register to vote or update your voter registration forms? ☐ Yes ☐ No

Would you like to be placed on our mailing list to receive general information? ☐ Yes ☐ No

What is your current Transportation? ☐ Drive ☐ Public Transit ☐ Family/Friend ☐ Other

What are your Living Conditions? ☐ Live Alone ☐ Live w/family or roommate ☐ Assisted Living

Are your Living Conditions Accessible? ☐ Yes ☐ No Do you need Accessibility? ☐ Yes ☐ No

Do you have a Spouse/Partner? ☐ Yes ☐ No Do you need a Caregiver? ☐ Yes ☐ No

What Services are you Requesting? (*Check all that apply*)

☐ Advocacy ☐ Information & Referral ☐ Independent Living Skills

☐ Peer Support ☐ Transition Services ☐ Emergency Preparedness

☐ Diversion ☐ Program: Please specify: _____

☐ Other: Please specify _____

CONSUMER: _____

STAFF: _____