

CONSUMER APPLICATION



*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: _____ Veteran: Yes No DD214

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 Specific Program: _____

Other: Please specify _____

Consumer/Caregiver: _____

Staff: _____

