Application for Services

3272 Sonoma Blvd. Suite 4, Vallejo, CA 94590
Phone: 707-552-2935 Fax: 707-561-0315

Please email or fax application with IPP and CDER

Day Programs		Independent Living Skills
☐ **Alternatives in Curriculum and Training (ACT)**	☐ **Tailored Day Service (TDS)**	☐ **Transitional Service (TS)**
• Full-time behavioral day program • Vendor #H13194, Service Code 515 • Tami Huizen, Day Program Coordinator Tami@thearcsolano.org	• Part-time day program • Vendor #H13194, Service Code 515, Sub-Code TDS-1 • Mary Vieira, Director of Services mary@thearcsolano.org	• ILS training program • Vendor #H05610, Service Code 520 • Jeninne Grigsby, TS Supervisory Instructor Jeninne@thearcsolano.org

For more information on our programs, please visit www.TheArcSolano.org

Consumer Information:

Name: _____ Phone: _____

Address: _____
(Number) (Street) (Apt.) (City) (Zip)

Current Living Arrangement:

☐ Family Home	☐ SLS *Agency name:*
☐ Care Home/CCF	☐ ILS *Agency name:*
☐ FHA	Living Independently/no supports *Roommate(s)?* ☐ Yes ☐ No
☐ Other:	

DOB:_____ SSN:_____ UCI:_____

Qualifying Disability: ☐ ID ☐ CP ☐ Epilepsy ☐ ASD ☐ 5th Category _____

Additional disability info: _____

Significant Others:

Primary Contact:	2nd Contact:
Relationship:	Relationship:
Contact #:	Contact #:
Lives w/client? ☐ Yes ☐ No	Lives w/client? ☐ Yes ☐ No

NBRC Information:

SC:	Phone:	Email:
Referral Date:	Desired Start Date:	Sign:

Please Complete Backside

Qualifying Information:

Is applicant mentally and physically capable of leaving the building in case of an emergency? ◯ Yes ◯ No

Is applicant ambulatory? ◯ Yes ◯ No (walkers/canes ok)

Is applicant continent? ◯ Yes ◯ No

Will applicant require any personal care from the Arc-Solano staff? ◯ Yes ◯ No

If yes, explain: _____

Does applicant have seizures? ☐ Yes ☐ No What type? _____

Does applicant require protective devices? ☐ Yes ☐ No Describe: _____

Dietary Restrictions: _____

Severe Allergies: _____

ACT/TDS: Does applicant require a 1:1 staffing ratio? ☐ Yes ☐ No

Can applicant participate in community outings at a small group ratio? ☐ Yes ☐ No

TS: Will applicant's needs be met with under 36 hours of service/month? ☐ Yes ☐ No

Healthcare Information:

PCP: _____ Phone: _____

Address: _____

Dentist: _____ Phone: _____

Address: _____

Insurance & number: _____ Medi-cal #: _____

Other:

School/Work/Training Experience:

_____

_____

Current excessive behaviors (i.e. AWOL, aggression, self-abuse):

_____

_____

Expectations for applicant in program

_____

_____

Long-range goals for applicant:

_____

_____