



REGISTRATION FORM

Day Support Peers

Administrative Offices
950 Slater Road, New Britain, CT. 06053
Ph 860-229-6665 Fax 860-826-6883 Web ccarc.com

Name: _____ Date: _____

Address: _____ SSN # _____

Home Phone: _____

Emergency Contact: _____

Emergency Contact Telephone: _____

Emergency Contact Address: _____

Date of Birth: _____ Birth Place: _____

DMR #: _____ DMR Class Member: Yes No

Citizenship Status: _____

Legal Status: Probated Non-Probated Limited or Full

Name of Legal Guardian: _____ Telephone Number: _____

Address of Legal Guardian: _____

Name of Parent: _____ Telephone Number: _____

Address of Parent: _____

FINANCIAL STATUS: (Please check/fill in all that apply)

SSI – Supplemental Security Income Social Security Disability Income (SSDI) (to include those individuals who are collecting from their parents Social Security Number)

Medicare: Part A (Hospital) Medicare: Part B (Supplemental Medical Insurance
List Medicare Number: _____

Medicaid/Title XIX: List Number: _____

Aid to the Disabled (A.D.) Private Health Insurance (List Name & Number Below)

Other: _____

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MEDICAL INFORMATION:

Physician: _____

Physician Telephone: _____

Physician Address: _____

Hospital Preferred: _____

Allergies (Indicate in Red Ink): _____

Diagnosis: _____

Age at onset of disability: _____

Physical Limitations: _____

Ambulation: fully ambulatory/no restrictions ambulatory/no stairs

ambulatory w/restrictions (i.e., cane) utilizes wheelchair

Seizure Activity: Yes/controlled Yes/uncontrolled No

Seizure Activity (Please be specific in explaining frequency and actions during the seizure):

Special Diet: _____

Corrective Lenses: Yes No

Hearing Aids: Yes No Right Ear Left Ear Both Ears

Communication: Speaks Clearly Speaks Unclearly Uses Sign Language

Uses Gestures/Sounds Uses Other (explain) _____

Other Medical Concerns: _____

Permission for emergency medical treatment (**only in the event that a guardian cannot be reached**)

Yes No

Signature of Participant or Guardian: _____

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EDUCATIONAL/VOCATIONAL BACKGROUND:

List all schools, programs, workshops, hospitals previously attended and their address:

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social interactions (please describe): _____

Does the individual have special interests or hobbies? _____

SELF CARE SKILLS:

Can individual feed self? (please describe): _____

Can individual bathroom self? (please describe): _____

Can individual dress/undress self? (please describe): _____

Other comments: _____

What goals do you feel are most important to the individual and his/her program? _____

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Habilitation problems (reason for referral): _____

Individual referred by: _____ Telephone Number: _____

Address: _____

DMR Case Manager: _____ Telephone Number: _____

Address: _____

Signature of person submitting form: _____