Vocational Services
(337) 989-1803
(337) 981-4925 Fax

303 New Hope Road
Lafayette, LA 70506
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Leading the Way for Persons with Developmental Disabilities

Application for Vocational Services

A. Applicant DATE OF APPLICATION: ___/___/___

APPLICANT'S NAME: _____ GOES BY NAME: _____

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

DIRECTIONS TO APPLICANT'S HOME: _____

BIRTHDATE: ___/___/___ PHONE: (___) ___ - ___ SEX: ___

RACE: _____ SOCIAL SECURITY#: ___ - ___ - ___ MARITAL STATUS: _____

OF APPLICANT'S CHILDREN: ___

☑ ALL APPLICANT RECEIVES: SSI ☐ MEDICARE ☐ MEDICADE ☐ SOCIAL SECURITY ☐ NOW ☐

SUPPORTS WAIVER ☐ OCDO ☐ OTHER _____

☑ APPLICANT'S LEGAL STATUS: COMPETENT MAJOR ☐ INTERDICTED ☐ CONTINUING TUTORSHIP ☐

NAME OF PARENT/GUARDIAN OF APLLICANT: _____

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

PHONE (Specify Work/Home/Cell) : (____) ____ - ____ (____) ____ - ____

Email Address: _____

PERSON WITH WHOM APPLICANT RESIDES/ RELATIONSHIP: _____

PHONE (Specify Work/Home/Cell): (____) ____ - ____ (____) ____ - ____

EMERGENCY CONTACT: (____) ____ - ____ (____) ____ - ____

OTHERS IN HOUSEHOLD OR RESIDENCE:

NAME: RELATIONSHIP:

_____ _____
_____ _____
_____ _____
_____ _____

REFFERAL SOURCE: _____ PHONE: (____) ____ - ____

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

REASON FOR REFFERAL: _____

IF WAIVER CLIENT, CASE MANAGEMENT AGENCY: _____

PHONE: (____) ____ - ____ CASE MANAGER: _____

B. MEDICAL DATA

PRIMARY DISABILITY/DIAGNOSIS:

SECONDARY DISABILITY/DIAGNOSIS:

DOES APPLICANT HAVE A CONVULSIVE DISORDER?

IF SO, ARE SEIZURES UNDER CONTROL?

DOES APPLICANT TAKE ANY TYPE OF MEDICATIONS?

IF SO, PLEASE LIST:

MEDICATION	PURPOSE

IF APPLICANT NEEDS A SPECIAL DIET (low calorie, diabetic, chopped foods, won't eat certain foods, etc.), PLEASE EXPLAIN:

DESCRIBE ALL PHYSICAL IMPERIMENTS:

LIST ANY CORRECTIVE AIDS (glasses, hearing aid, braces, dentures, etc.):

LIST MEDICAL, MENTAL HEALTH, REHABILITATION, OR OTHER TESTING OR TREATMENT APPLICANT HAS RECEIVED:

NAME	ADDRESS	SERVICE RENDERED	DATE OF SERVICE
			/ /
			/ /
			/ /

C. PROGRAMMATIC

WHAT ARE APPLICANT'S EXPECTATIONS ABOUT LARC'S PROGRAM?

WHAT KIND OF WORK DOES APPLICANT LIKE OR WANT TO DO?

HAS APPLICANT EVER HAD A JOB? IF SO, LIST WHERE, HOW LONG, TYPE OF WORK APPLICANT PERFORMED

LOCATION:	HOW LONG:	JOB DUTIES:

WHAT DOES APPLICANT DO IN FREE TIME?

WHAT SCHOOLS OR TRAINING HAS APPLICANT ATTENDED?

WHERE?	WHEN?

HAS APPLICANT EVER LIVED IN A STATE-SUPPORTED OR PRIVATE RESIDENTIAL CARE FACILITY?

WHERE?	WHEN?

HAS APPLICANT EVER BEEN CONVICTED OF A FELONY? ☐ IF SO, PLEASE EXPLAIN BELOW:

D. PERSON ASSISTING IN COMPLETING APPLICAITON IF OTHER THAN APPLICANT:

NAME	RELATIONSHIP TO APPLICANT

E. I HEARBY REQUEST ADMISSION TO LARC'S VOCATIONAL PROGRAM

APPLICANT	/ /
PARENT/GUARDIAN, IF REQUIRED	/ /

Vocational Services
EMERGENCY MEDICAL CARE RELEASE

LARC has my permission to secure emergency medical care should the need arise for

CLIENT

Signed: Date: / /

PHYSICIAN:

NAME

ADDRESS

( ) -

PHONE

DENTIST:

NAME

ADDRESS

( ) -

PHONE

PREFERRED HOSPITAL:

RELEASE PERMIT

I, the undersigned, hereby authorize

to release to

NAME

STREET NUMBER CITY STATE ZIP

ANY OR ALL MEDICAL, SOCIAL, PSYCHOLOGICAL, AND EDUCATIONAL INFORMATION IN THE RECORD OF

FOR THE PURPOSE OF

THIS RELEASE IS VALID FROM TO

RECIPIENT SIGNATURE DATE

LEGALLY RESPONSIBLE GUARDIAN DATE

WITNESS DATE

WITNESS DATE