

PARTICIPANT INFORMATION

Name: _____ Self-Direction Plan? Yes No
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

CURRENT LIVING ARRANGEMENT

What type of housing does participant live in? House Apartment Certified Setting
Other (please describe): _____
How long has participant lived in current home? _____
Does participant live with family members? Yes No _____
Does participant live with roommates? Yes No How many? _____
Does participant have staff who assist in the home? Yes No
If yes, how many hours per week is staff in the home? _____

CIRCLE OF SUPPORT

Support Staff Name: _____ Phone: _____
Support Staff Email: _____
Fiscal Intermediary Name: _____ Phone: _____
FI Email: _____
Family Member: _____ Phone: _____
Email: _____
Relationship to Participant: _____
Who is the best person to contact about this application? _____
Please describe any additional considerations: _____

Please complete and return to Jen Ralph, Program Coordinator:
jenralph@communityhealthstrategies.com
(585) 383-6543

www.communityhealthstrategies.com