*Member Application*

Applicant Information

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Needs PEP Transportation: YES____NO____

Has an intellectual and/or developmental disability: YES___ NO ___ Please describe: _____

_____

_____

Has a mental health diagnosis: YES ____ NO ___ List diagnoses (i.e. anxiety, panic attacks, OCD, impulse-control disorders, etc.): _____

_____

_____

Case Manager Name: _____ Requires Adaptive Equipment: YES __ NO ___

Has Medicaid Waiver: YES ____ NO ____ Will take medication at PEP: YES ____ NO ___

On Medicaid Waiver Waitlist: YES ___ NO ___ Has History of Seizures: YES ____ NO ____

Requires individualized care: YES ____ NO ____ If yes, please describe (i.e. toileting, feeding, etc.):

_____

How do you communicate? (i.e.: Verbally fluent English, verbally limited English, verbally fluent Spanish, verbally limited Spanish, Non-verbal, American Sign Language/ASL, etc.):

_____

Strengths (skills, interests, talents): _____

_____

Mobility supports needed (if applicable): _____

_____

Behavioral supports needed (if applicable): _____

_____

Please use this space to provide any additional information you would like PEP to consider (i.e. how many days/week will the individual attend PEP, interest in employment, goals and dreams, etc.):

_____

_____

_____

_____

Person Completing Intake Form

Name(s): _____

Relationship to applicant: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

***By signing below, I certify that all information provided is true and complete to the best of my knowledge. I understand that sharing accurate and relevant behavioral and medical history is important to ensure that the best-quality support, safety, and care is provided.***

Applicant Signature: _____ Date: _____

*Forms completed online should be emailed to Allison.Burnett@pephhi.org or dropped off at the PEP office, located at 39 Sheridan Park Circle, Suite 2, Bluffton, SC 29910, Attn: Allison Burnett.*