APSI SERVICE REQUEST APPLICATION

1. Demographics

Person's First Name: Person's Last Name:
Person's Address:
Telephone Number:
Date moved to this address:

Date of Birth: Social Security Number:
Gender: Race:
Date of Request for Service: County of Residence:

Referring Party Information
Name:
Address:
Telephone Number:
Email Address:

Please check best description of your role to the applicant:

- Provider
- Family Member
- Attorney / Court
- SSA / County Board Staff
- Community Member

Please identify the professional primary contact

- Check if same as referring party information
  - Name:
  - Address:
  - Telephone Number:
  - Email Address:

Please identify the personal primary contact

- Check if same as referring party information
  - Name:
  - Address:
  - Telephone Number:
  - Email Address:

Does this person have a Do Not Resuscitate Order? Yes No
If yes, must attach order with this application.

Does this person have a Living Will? Yes No
If yes, must attach with this application.

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Does this person have a Power of Attorney? Yes No
If yes, must attach with this application.

Does this person have a burial account? Yes No
If yes, must attach with this application.

2. Eligibility Requirements

Is the person 18 years old or older? Yes No
(Must include a copy of birth certificate)

Is the person a resident of the State of Ohio? Yes No

County Board of Developmental Disabilities Eligible? Yes No
Evidence of county board eligibility required. Provide a copy of either the Ohio Eligibility Determination Instrument (OEDI) or Level of Care (LOC).

APSI provides service as the entity of last resort. Referral source is required to identify less restrictive options that were considered.

Other guardianship options:
Name / Agency:
Telephone Number:
Address:
Email Address:
Date Contacted:
Reason unable to provide guardianship:

Healthcare power of attorney:
Name / Agency:
Telephone Number:
Address:
Email Address:
Date Contacted:
Reason unable to provide guardianship:

APSI provides service as the entity of last resort. Referral source is required to identify next of kin contacted for consideration for guardianship and reason they cannot be guardian.

Full Name:
Telephone Number:
Address:
Email Address:
Relationship to applicant:
Date Contacted:
Reason unable to provide guardianship:

Full Name:
Telephone Number:
Address:
Email Address:
Relationship to applicant:
Date Contacted:
Reason unable to provide guardianship:

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Full Name:
Telephone Number:
Address:
Email Address:
Relationship to applicant:
Date Contacted:
Reason unable to provide guardianship:

Full Name:
Telephone Number:
Address:
Email Address:
Relationship to applicant:
Date Contacted:
Reason unable to provide guardianship:

3. Service Need

Has the person recently lost a primary caregiver? Yes No
If yes, was the caregiver a
Parent Other Family
Sibling Other
If yes, when did this loss occur? Month--- Day ------ Year ------

Why is this caregiver not available?
Death Moved to another state Other
Resigned Ageing caregiver

Can the person communicate their wishes & needs? Yes No

What is the person's primary communication style?
Verbal sign language
Communication device gestural & non-verbal sounds

Is the person in need of someone to assist with medical decisions and treatment needs?
Yes No
Please identify current medical diagnosis.

Please identify current psychiatric diagnosis.

Please identify developmental disability diagnosis.

Is the person in need of someone to assist with community placement and service needs?
Yes No

Person's residential address:
Provider name and contact information:
Type of setting:
ICF DC
Community Waiver Home Family Home
Independent Living Other

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Person's day services address:
Name of day services:
Provider name and contact information:
Type of day services:
Sheltered Day Program
Community Employment

Does the person need assistance in making decisions and explaining their reasoning?
Yes No
If yes, who currently assists the person with decision making?
Full Name:
Telephone Number:
Address:
Email Address:
Relationship to person:

Does the person need assistance in acquiring needed supports?
Yes No

Why is the person being referred for guardianship services?

As the referral source, what do you want APSI to do?

Has the person received an expert evaluation identifying a need for protective services?
Yes No
If yes must attach a completed Expert Evaluation completed less than 60 days prior to this application. Expert Evaluation must be signed by physician or licensed psychologist.

All information on this form must be completed and requested supplemental documentation must be provided in order for this request to be considered.

Check the following attachments required to be included in this application:
County Board Eligibility Determination Instrument or Level of Care
Birth Certificate
Social Security Card
Expert Evaluation

Check if the additional information is included is this application
Burial Account Information
Do Not Resuscitate Order
Living Will
Power of Attorney

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Signature of person completing this application Date

FOR APSI USE ONLY

Regional Program Director Signature: Date

Did Regional Program Director document this service request?

Yes No

Regional Program Director Recommendation:

Person is eligible Person is not eligible

Place on Wait List Do not place on Wait List

APSI ACTION (to be completed by Program Coordinator)

Place on Wait List

Do Not Place on Wait List

Program Coordinator Signature Date

Regional Program Director is required to document name, date and time placed on wait list or that the person is not eligible.

Approved August 2016