LIVES WITHOUT LIMITS

TAKE AIM · SUPPORT LWL ·

Application for Receiving Services

Date: _____

Name: _____

Address: _____

Mailing address (if different from above): _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail: _____

Date of Birth (mm/dd/yyyy): _____ Circle one: *Male* or *Female* ?

Name of Nearest Relative: _____

Relationship: _____

Phone Number(s): _____

Address: _____

_____

Marital Status (Check one): ▫ Single ▫ Married ▫ Divorced

What is your primary disability? _____

What caused your disability and at what age? _____

_____

Please list any secondary disabilities, if any: _____

_____

Is your disability progressive? _____

What is your approximate height and weight? _____

What services are you requesting? _____

Please check all that apply:

What are the effects of your disability?

- ▫ Deafness
- ▫ Speech Impairment
- ▫ Reduced Stamina
- ▫ Hearing Loss
- ▫ Coordination Problems
- ▫ Limited Mobility
- ▫ Memory Loss
- ▫ Spasticity
- ▫ Slowed Development
- ▫ Vision Impairment
- ▫ Muscular Weakness
- ☐ Other: _____

Do you have any problems with…?

- ▫ Allergies
- ▫ Chronic Pain
- ▫ Heightened Emotions
- ▫ Depression
- ▫ Skin Sensitivity
- ▫ Balance
- ▫ Brittle Bones
- ▫ Heat/Cold Sensitivity

☐ Seizures—if yes, what type and how often? _____
_____

Also, what treatments or medications are you using or have you used to control your seizures? _____
_____

Do you use any of the following aids or assisting devices?

- ▫ Prosthesis
- ▫ Leg Brace
- ▫ Electric Wheelchair
- ▫ Manual Wheelchair
- ▫ Wrist Brace
- ▫ Hearing Aid
- ▫ Crutch/Cane
- ▫ Walker

☐ Other: _____

Are you active in the military, a veteran, or a dependent of an active member of the military or veteran? If yes, please explain. _____
_____

Primary Care Physician, PT, OT and/or Other Health Professional Important to Your Care (Please list with phone numbers): _____
_____
_____
_____

Housing: ▫ Home ▫ Apartment ▫ Other (Describe): _____

▫ Own ▫ Rent

Living Arrangement (Please list all those living with you):

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have an attendant? _____ ▫ Full-time ▫ Part-time

Please describe your home and your neighborhood (i.e., quiet, lots of visiting children, close to retail/commercial, suburban, rural, lots of traffic, etc.): _____
_____
_____
_____

Do other people live with you or assist you frequently? If so, please describe (including tasks & chores). Who is responsible for your care if you are not independent? _____
_____
_____
_____

Does anyone in your household have concerns about you receiving our services? If so, please describe: _____
_____
_____

Are you currently employed? If so, do you need help with equipment or tasks while at work? In what way? _____

_____

_____

Are you currently in school? If so, do you need equipment or services to assist you while in school? In what way? _____

_____

_____

_____

_____

Choose five of the following feelings you have experienced in the last week:

☐ serious	☐ slow	☐ playful	☐ slow	☐ calm
☐ willing	☐ attentive	☐ energetic	☐ sensible	☐ responsible
☐ smart	☐ protective	☐ dependable	☐ stable	☐ confident
☐ happy	☐ sweet	☐ easy going	☐ independent	☐ assertive
☐ devoted	☐ friendly	☐ dependent	☐ loving	☐ trusting
☐ excitable	☐ communicative			

Choose five of the following words that would describe feelings you have not experienced in the last week.

☐ serious	☐ indifferent	☐ distracted	☐ slow	☐ calm
☐ playful	☐ manipulative	☐ stubborn	☐ protective	☐ resistant
☐ jealous	☐ fearful	☐ excitable	☐ assertive	☐ joking
☐ foolish	☐ dependent	☐ no-nonsense		

Describe your means of transportation: _____

_____

_____

_____

Are you available to attend different fundraising events around South GA? _____

_____

_____

How do you feel a service from us could improve your life? With what specific tasks would you hope we could help you with? _____

_____

_____

_____

_____

Please tell us a little more about yourself—hobbies, activities, clubs, interests, etc.: _____

_____

_____

_____

_____

_____

_____

Because it is important to teach others about serving others that are in need, community service is all that we ask in return for assistance from us. What kind of community service would be of interest to you? _____

_____

_____

_____

_____

_____

What questions or concerns do you have that we may address? _____

_____

_____

_____

_____

_____

_____

Please send with your application the following:

1. A short autobiography
2. A recent photo of yourself
3. The dimensions (width & length) of your mobility device if you have one.

Applicant Signature: _____ Date: _____

Please return to:

Lives Without Limits, LLC
P.O. Box 1652
Thomasville, GA 31799-1652