

Side By Side Supported Living, Inc. Request for Services

FORM A

INSTRUCTIONS: The applicant, his or her legal guardian, or someone assisting the applicant, should complete this application.

Name: _____

Address: _____

Day Telephone# _____ Evening Telephone# _____

Date of birth: _____ Age _____ Gender: M / F

Race/Ethnicity: _____

Preferred Language: _____

Are you literate in your native language? Yes No Limited

Do you speak English? Yes No Limited

Are you literate in English? Yes No Limited

Religion/Spirituality: _____

Do you have a court appointed legal guardian? Yes No

Name of legal guardian: _____

Relationship to you: _____

Telephone#: _____ Other: _____

Emergency contact person: _____ Phone: _____

Health insurance provider: _____ Plan: _____

Name of Policy Holder: _____ Policy # _____

What is your disability?

Please write about some of the important happenings in your life.

1470 Beacon Street, Suite B
Brookline, MA 02446

Phone: (617) 277-6140

Fax: (617) 277-0168

Name _____

Date of Birth _____

What are your goals and dreams?

What holds you back?

How would you like your life to be different in the future?

What are some of your strengths?

What type of help would you like?

How will we know you are struggling? _____

Name _____

Date of Birth _____

Please indicate which of the following services you are applying for:

Side by Side Adventures:

- S Day trips
- D Social connection groups
- S Wellness program
- W Meditation and relaxation

In addition to this application, please complete and submit FORM D (SBS Adventures Registration Form).

Side by Side Living:

- S 1470 Beacon Street
- 1 Other residential options

In addition to this application, please have a family member complete FORM B (Family History) and have your current clinician complete FORM C (Clinician Referral Form).

Side by Side Works:

- S Vocational
- V Educational

In addition to this application, please submit a résumé.

Side by Side Counseling:

- S Individual
- I Group
- G Family
- F Parent support

In addition to this application, please have a family member complete FORM B (Family History) and have your current clinician complete FORM C (Clinician Referral Form).

Signature: _____ Date: _____

Print name: _____

Did someone help you complete this form? Yes No

Name: _____ Telephone: _____

How did s/he help you? _____
