Application For Services
Community Entry Services

Riverton	Lander	Jackson	Casper
2441 Peck Av	300 Lincoln	140 E. Broadway	437 S. Spruce
307) 856-5576	(307)332-7825	(307)733-7637	(307)577-3091

An Equal Opportunity Service Provider

Community Entry Services does not discriminate on the basis of race, color, religion, national origin, sex, age, disability, or any other status protected by law or regulation. It is our intention that all qualified applicants be given equal opportunity and that selection decisions be based on services needed and the availability of those services by CES.

General Information

Last Name | First Name | Middle Name

Address *Number* *Street* *City* *County* *State* *Zip Code*

Telephone Number(s) | Social Security Number

Date of Birth | Place of Birth *City and State*

Height | Weight | Hair Color | Number of Dependents | Number of Persons in Household

Marital Status: ☐ Single ☐ Married ☐ Divorced

Sex: ☐ Male ☐ Female

Family Information

Father:

Last Name | First Name | Middle Name

Address *Number* *Street* *City* *County* *State* *Zip Code*

Telephone Number(s) | Social Security Number

Date of Birth | Place of Birth *City and State*

Mother:

Last Name | First Name | Middle Name

Address *Number* *Street* *City* *County* *State* *Zip Code*

Telephone Number(s) | Social Security Number

Date of Birth | Place of Birth *City and State*

Siblings:

Name	Date of Birth	Live at Home?	
_____	_____	☐ Yes	☐ No
_____	_____	☐ Yes	☐ No
_____	_____	☐ Yes	☐ No
_____	_____	☐ Yes	☐ No

Guardianship/Conservator Status:

Note: Social Security Payee and custody granted during a divorce while the individual was a minor DO NOT constitute guardianship. Court documents must be attached or guardian status may not be honored.

Last Name | First Name | Middle Name

Address *Number* *Street* *City* *County* *State* *Zip Code*

Telephone Number(s)

Referral Data

Diagnosed Disability of Applicant: _____

Cause: _____ Age of Onset: _____

Rehabilitation Service Needs: *Check all that apply.*

☐ Life Skills Training ☐ Social Skills Training ☐ Residential Services ☐ Evaluation Services

☐ Deaf/Blind Services ☐ Job Placement ☐ Job Coaching ☐ Other (Specify) _____

☐ Day Services

Behavioral Difficulties: *Check all that apply.*

☐ Hurt Self ☐ Hurt Other People ☐ Sex Offender

☐ Abused Alcohol or Other Drugs ☐ Has Been Convicted of a Crime

Other Agencies Currently Involved: *Include name of case manager if individual has one.*

_____ _____

_____ _____

Funding Sources *List current funding sources, such as, private pay, adult waiver, children's waiver, worker's comp., Vocational Rehabilitation, school district, etc.*

_____ _____

_____ _____

Financial Information *Check all of the income sources below that apply. Please list the amount received per month from that source.*

☐ Social Security(SSDI/SSA) Amount: _____ Account number: _____

☐ Supplemenatl Social Sec. (SSI) Amount: _____ Account number: _____

☐ Veteran's Administration Amount: _____ Account number: _____

☐ Railroad Retirement Amount: _____ Account number: _____

☐ Parents Amount: _____

☐ Self Amount:

Do you have a representative payee? _____Yes _____No Name and Address:_____

Please return signed Release of Information forms for each source of income to allow CES to obtain verification

Please return signed Release of Information forms for the facilities listed below to allow CES to obtain needed information.

Education

	Elementary School				High School				Other				Other			
School Name and Location *Include City and State*																
Years Completed	5	6	7	8	9	10	11	12	1	2	3	4	1	2	3	4
Describe Course of Study																
Dates Attended	From		To		From		To		From		To		From		To	

Work History *Start with your most current employer.*

Name of Employer	Address	Dates Employed(Month/year) From	To	Hourly Rate/Salary Starting	Final	Reason for leaving

Testing / Evaluation

	Name of Physician	Address	Type of Testing
Medical			
Neurological			
Psychological			
Work Evaluation			
Other			
Other			
Other			

Bank Accounts / Trust Funds *Please list all checking, savings and trust accounts.--Not needed if private pay*

Name of Bank	Address *Including City and State*	Amount in Account	Account Number

Insurance Information

	Name of Insurance Carrier	Address *Including City and State*	Group Number
Health			
Life			

Medicare ☐ Yes ☐ No Medicaid (Title 19) ☐ Yes ☐ No BIA / IHS ☐ Yes ☐ No

Account # _____ Account # _____

Other Information *Note any other information you would like to have considered in reviewing your application. Use another sheet of paper if necessary.*

_____

_____

_____

_____

_____

Signatures

I, _____, desire to enter the Community Entry Services program.

_____ _____

Applicant or Guardian Signature Date

_____ _____

Referring Agent Date

_____ _____

Information Source (If Different From Applicant or Guardian) Date