#1 McCord Road
Houma, LA 70363
Phone: 985.876.4465
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App. Rec. _____

Application Form

Please identify the services you are applying for:

_____ Residential _____Non-work Day Program _____ Supported Employment

1. ***Personal Information***

Full Name of Applicant: _____

Race: _____ Date of Birth: _____ Place of Birth: _____

Eye Color: _____ Hair Color: _____ Weight: _____ Height: _____

Identifying Marks: _____

Contact Person: _____ Relationship to Applicant: _____

Phone Number: _____ Alternate Phone Number: _____

Home Address: _____

City/State: _____ Zip: _____ Parish: _____

Mailing Address (if different): _____

Legal Status: ____ Competent Major ____ Partial/Full Interdiction ____Other(_____)
Legal documentation must be attached to this application if other than competent major

Primary Language: _____ Secondary Language: _____
Religion: _____

Does Applicant have a criminal history? _____ If yes, explain: _____

_____
(Documentation may be required.)

Marital Status: ____Single ____Married ____Divorced ____Widowed

2. Family Information

Father Full Name: _____ Phone #: _____

Father Birth Date: _____ Birth Place: _____

Employer: _____ Living in the home? _____

If not, where? _____
Street City State Zip

Marital Status: Married Divorced Widowed Remarried Deceased Single
(Circle One)

Mother Full Name: _____ Maiden Name: _____

Phone #: _____ Birth Date: _____ Birth Place: _____

Employer: _____ Living in the home? _____

If not, where? _____
Street City State Zip

Marital Status: Married Divorced Widowed Remarried Deceased Single
(Circle One)

If someone other than parents are responsible for applicant, please complete the following:

Name(s): _____

Relationship to Applicant: _____

Phone #: _____ Additional Phone #: _____

Street Address: _____ City/State/Zip: _____

Siblings:

Name	DOB	Gender	Lives at Home?	Employer

(List others on back side of sheet)

Others Living in the Home:

Name	Age	Relationship

3. Monthly Income of Applicant

Wages: $_____
SSI: $_____
Soc.Sec: SSDI: $_____
SSDAC: $_____
Other: $_____ _____

Medicaid Number: _____

Medicare Number: _____ Effective Start Date: _____

4. Medical/Diagnosis

Check those items which apply regarding diagnosis.

_____ Down Syndrome _____ Hydrocephaly

_____ Microcephaly _____ Cerebral Palsy

_____ Intellectual Disability _____ Medical Diagnosis

_____ Developmental Disability _____ Autism

_____ Seizure Disorder _____ Physical Disability

_____ Other: _____

Physician: _____ Phone #: _____ Date Last Seen: _____

Allergies: _____

List of Medications:

Medication:	Dosage:	Frequency:	Purpose:

(List others on back side of sheet)

5. Goals/Outcomes

What benefits are the applicant and family expecting to receive from participating in TARC's program?

_____
_____

What are the applicant's goals for the future?

_____
_____
_____
_____
_____
_____
_____

6. GENERAL CONSIDERATIONS AND AGREEMENTS

A. **All information is confidential.**

B. The completed application must be received by TARC's Intake Specialist. An interview with the applicant and responsible persons (parents, guardians, etc.) will be arranged. Final acceptance of the application will be after all forms are completed and reviewed by the TARC Admission Committee. Once accepted, the applicant and the persons responsible for the applicant will be contacted to set up Orientation.

C. The following forms or items are necessary for each applicant:

1. Application (completed and signed by applicant and parent/responsible party)
2. Medical record (90L, immunization record)
3. Psychological/Psychiatric Evaluation
4. Copy of Social Security Card
5. Copy of State ID
6. Copy of Medicaid and/or Medicare Card(s)
7. Supplementary/additional information, as requested.

D. All accepted applications will be reviewed periodically. An applicant shall be admitted to the program when an opening is available suitable for the applicant and a funding source is available. Admission into TARC is contingent on available openings, funding, and upon approval by the Admissions Committee.

E. All applicants will receive equal admission opportunities without regard for race, color, religion, sex, national origin, age, disability, marital status, veteran status, sexual orientation, genetic information, or another other protected characteristic under applicable law, unless the applicant has a severe emotional/psychological disability or another program exists in the parish that is more suitable.

F. The application is on a conditional basis. After 60 days, the applicant shall be considered permanent.

G. ***It is agreed by the undersigned that if the applicant, after admission to the program, is uncooperative with the system or develops a condition, which, after interventions, remains unmanageable, steps will be made to terminate services. TARC will then assist the individual in finding a more suitable program.***

H. It is agreed by the undersigned that if the applicant receives sufficient or maximum benefits from TARC programs and there is another more suitable program or employment opportunity, the applicant and responsible party will cooperate in the appropriate placement.

I. It is agreed that the applicant may participate in any on or off-campus training and educational opportunities, which may be a part of the TARC programs as required by OCDD standards.

J. In the event medication is necessary or shall become necessary, which must be administered during the day, the undersigned agrees to have a physician prescribe such and sign necessary release forms. MEDICATION MUST BE IN PRESCRIPTION BOTTLES, and have a doctor's order. For any special and/or restrictive diet, a signed doctor's order will also be submitted.

K. It is agreed by the undersigned that TARC may release necessary and pertinent information from client's file on application to the State of Louisiana, Department of Health and Human Resources, Office for Citizens with Developmental Disabilities (or whatever agency may supplant the above) and Louisiana Rehabilitation Services at the TARC staff's discretion. For all other information to be released, individual release forms shall be obtained.

L. **EMERGENCY TREATMENT AND/OR MEDICATION PERMISSION:**

In the event of an emergency, I authorize TARC personnel to seek medical treatment for me or my son/daughter/loved one _____. I know that I must assume all medical costs associated with such an emergency. Also, if I/my son/daughter/family member must take prescribed medication during the year, I give the nurse or other appropriate TARC staff my permission to administer this medication.
My hospital of choice is _____ if it becomes necessary for emergency treatment.

_____ _____

Applicant's Signature Date Parent's Signature Date

I, the undersigned, have read or had read to me and answered all of the above and know that, to the best of my knowledge, fair, true and accurate statements have been given.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent, Guardian or Other Responsible Person Date

Updated 6/15/2021