

- g. Community Mental Health (CMH) recipient
- h. Food Assistance recipient
- i. Family Independence Program (FIP) recipient
- j. State Disability Assistance (SDA) recipient
- k. Veteran Affairs recipient
- l. Other

2. Living Arrangement (Check all boxes that apply to you and answer related questions)

- a. Alone
- b. With spouse (If married answer questions below.)
 - Is spouse disabled? Yes No
 - Is spouse working? Yes No
 - Full name of spouse _____
- c. With children under age 18. How many? _____
- d. With others (relatives and non-relatives) How many? _____
- e. Live in adult foster care facility, home for the aged.
- f. Is client in a hospital or nursing home? Yes No
- g. Does the recipient have a guardian? Yes No
 - Name of guardian _____
- h. Is a caregiver/provider already identified? Yes No

Date of Birth _____

Read the following statement, sign, and date the application.

I wish to apply for one of the adult services programs. I certify that the information I have given is correct. By signing, I acknowledge that I have read and agree to the rights, responsibilities, and important things to know described in Section C of this application.

Signature of Client or Authorized Representative _____

Date _____