

**STEPPINGSTONES
MEMBERSHIP APPLICATION**

Applicant's Name: LAST FIRST

Address: STREET

CITY/TOWN STATE ZIP CODE

Home Phone Number: _____ Other Phone Number: _____

Email address: _____ Do you want to be on our e-mail list? Yes No

Date of Birth: _____ Gender: Male Female

=====

Do you have a family caregiver or professional caregiver assisting you? Yes No

Which agency is the professional caregiver from? _____

Address: _____

Phone Number: _____ Other Phone Number: _____

=====

Do you have a legal guardian? Yes or No **Please provide guardianship papers.**

Legal Guardian's name: _____

Address: _____

Phone Number: _____ Other Phone Number: _____

Email address: _____ Do you want to be on our e-mail list? Yes No

=====

EMERGENCY CONTACT INFORMATION:

Primary Contact Name: _____

Relationship to the applicant: _____ Email: _____

Home Phone Number: _____ Other Phone Number: _____

Secondary Contact Name: _____

Relationship to the applicant: _____ Email: _____

Home Phone Number: _____ Other Phone Number: _____

REHABILITATION INFORMATION

Important: Please substantiate your brain injury, course of treatment and present condition with documentation from a health care professional. Please attach this information to this application.

Please circle the cause of the brain injury: acquired brain injury stroke brain tumor other: _____

Date of injury: _____

Past Rehab Experience (please circle): None OT PT SLP Other: _____

Current Rehab Activities (please circle): None OT PT SLP Other: _____

MEDICAL INFORMATION

List allergies (i.e.: food, insect, bees, etc.):

If you have allergies, what are symptoms of your allergic reaction that would help staff to identify it?

Chronic illnesses (i.e.: seizures, diabetes, epilepsy, asthma, etc.):

List any medication or treatment you carry with you during the day for chronic illnesses or allergies (i.e. epi-pen, insulin, etc):

List any assistive/adaptive equipment you use to maintain independence:

Do you have a mental health treatment background? Yes or No Please describe:

Do you have a substance abuse treatment background? Yes or No Please describe:

RESIDUAL CHALLENGES

Please circle the types: Cognitive Physical Behavioral

What specific challenges do you currently encounter and how do they impact your daily functioning?

What adaptive or coping strategies assist you with these challenges?

What are your strengths?

I certify that the information in this application is true and accurate and I agree to notify SteppingStones, in writing, of any changes in my medical, emergency contact, and financial information.

Applicant's Signature

Date

Guardian's Signature (if applicable)

Date

FINANCIAL INFORMATION: INCOME

What is your present average monthly income after taxes?

Employment	\$
Unemployment benefits	
Worker's Comp	
Rental income	
Trust or interest income	
Retirement income	
Child Support	
Other (please specify)	
Other (please specify)	
PUBLIC ASSISTANCE	
AFDC/TANF	
SSDI SSI SSA (please circle if applicable)	
APTD	
General Assistance or Town Welfare	
Food Stamps	
Fuel Assistance	
VA Disability	
HUD Housing	
Other (please specify)	
TOTAL MONTHLY INCOME	\$

Who else contributes to the household income?

Name	Source Of Income	Monthly Amount
		\$
TOTAL MONTHLY HOUSEHOLD INCOME		\$

ASSETS: Please describe your own and your household's saving and assets

Asset	Amount or Value	In whose name
Savings		
Checking		
CD (maturity date)		
IRA (maturity date)		
Other		
TOTAL HOUSEHOLD ASSETS		

SteppingStones Membership Contribution: \$ _____