

**Parent Application**

Please complete all items on this application. Your answers will help our program to determine if your son or daughter is a suitable to be a member of the program and to better serve them if accepted.

Date: \_\_\_\_\_

**I. General Information**

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mothers Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Fathers Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Custody: \_\_\_\_\_

Guardianship: \_\_\_\_\_

Parent Responsible for Tuition: \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Both

Please record the names and ages of all siblings.

Brother/Sister	Age	Name

**II. Medical Information**

1. Once accepted to the STEP Program, a member is required to submit a completed medical form.
2. If the applicant takes medication, they must be able to monitor their medication.
3. Please describe and comment on any physical conditions or limitations that you find pertinent.

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**III. Independence Skills**

Please complete the following chart.

My son/daughter can:

	Never Tried	Not At All	With Help	Yes
Cook a Snack				
Cook a Meal				
Do Laundry				
Make a Bed				
Wash Dishes				
Make Change				
Shop for Clothing				
Shop for Food				
Use Public Transportation				
Drive a Car				

Additional information on about needs or abilities in the area of independent living skills:

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The STEP Program requires two written recommendations. These should come from individuals who are outside of the family. Teachers, guidance counselors and former employers are suggested sources for obtaining recommendations.

Recommendations will be sent from:

Name: \_\_\_\_\_

Title/Postion:\_\_\_\_\_

Address:\_\_\_\_\_

\_\_\_\_\_

Work Phone:\_\_\_\_\_

Name: \_\_\_\_\_

Title/Postion:\_\_\_\_\_

Address:\_\_\_\_\_

\_\_\_\_\_

Work Phone:\_\_\_\_\_

#### IV. Vocational History

Has the applicant ever retained a volunteer or internship position? \_\_\_\_\_ Yes

\_\_\_\_\_ No

If yes, Name of Company? \_\_\_\_\_ From : \_\_\_\_\_ To \_\_\_\_\_

Name of Company \_\_\_\_\_ From: \_\_\_\_\_ To \_\_\_\_\_

Name of Company \_\_\_\_\_ From: \_\_\_\_\_ To \_\_\_\_\_

Does the applicant express any interest in a particular vocational area?

\_\_\_\_\_

\_\_\_\_\_

Has the applicant ever held a paying job? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Name of Company? \_\_\_\_\_ From : \_\_\_\_\_ To \_\_\_\_\_

Name of Company \_\_\_\_\_ From : \_\_\_\_\_ To \_\_\_\_\_

Name of Company \_\_\_\_\_ From : \_\_\_\_\_ To \_\_\_\_\_

**V. Social Background**

Please use the following scale to rate the applicant's skill in relation to the following groups:

- (1) Little or no difficulty
- (2) Might have some difficulty
- (3) Likely to have difficulty

Peers: \_\_\_\_\_ Co-Workers: \_\_\_\_\_  
Young Children: \_\_\_\_\_ Supervisory Adults: \_\_\_\_\_

Additional Comments:

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Please explain and comment on any experiences your son or daughter has had living away from home (for a minimum of four weeks) please include dates, duration of time, and any difficulties.

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