Program Application

Please Return to: After Gateway ●
501 S. Mendenhall Street ● Greensboro, NC 27403
Phone (336) 379-7670 ● fax (336) 379-7317

Date of Application: _____

Please enclose a $25 non-refundable application fee. Thank you.

Applicant's Information:

Name: Last _____ First _____ Middle _____

Age _____ Date of Birth _____ Weight (lbs) _____ Medicaid ID# _____

Social Security# _____ County of Residence _____

Education Level Completed _____ Primary Language (if non-verbal, please indicate) _____

Address _____ City/State _____ ZIP _____

Home Phone _____ Cell Phone _____ Other Phone _____

Legal Guardian _____ Relationship _____

Address _____ City/State _____ ZIP _____

Home Phone _____ Cell Phone _____ Other Phone _____

Emergency Contact Name _____ Relationship _____

Address _____ City/State _____ ZIP _____

Home Phone _____ Cell Phone _____ Other Phone _____

Applicant's Medical History/Care Needs:

Primary Diagnosis _____ Secondary Diagnosis _____

Seizure Disorder? Yes (what kind?) _____ No _____

Medical Treatments Required (what/how often?) _____

_____

Behavior Issues (what/how often/how treated?) _____

_____

Ambulatory? Yes _____ assistance needed? _____ No _____

Need assistance with toileting? Yes _____ (what?) _____ No _____

Need assistance with feeding? Yes _____ (what?) _____ No _____

Special Diet? Yes _____ (what?) _____ No _____

Medications Taken

Name	Dosage	Time	Route

Applicant's Service Needs:

Days and Times Requested _____

Requested Start Date at After Gateway _____ Mode of Transportation _____

Funding Source? CAP-MR/DD _____ Other (what?) _____ None _____

Current Day Activity _____

Signature of Applicant, Guardian, or Responsible Party _____ Date _____