easterseals
Eastern Pennsylvania

LEAP Program Application

Return this form to Cynthia Phillips
cphillips@esep.org • 610.289.0114 x229

Name (First, middle, last): _____ DOB: _____

Gender: _____ Female _____ Male _____ Intersex _____ Non-binary _____ Transgender
_____ Not listed _____ Prefer not to answer

Address: _____ City: _____ State: ____ Zip: _____

School district: _____ County of residence: _____

Home phone: _____ Cell phone: _____

Email address: _____

Student status: _____ Full time _____ Part time _____ None

Marital status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Preferred language: _____ English _____ Spanish _____ Other: _____

Interpreter required: _____ Yes _____ No

Race: _____ American Indian/Alaskan Native _____ Asian _____ Black/African American
_____ Native Hawaiian/Pacific Islander _____ White _____ Two or more races _____ Other

Ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino _____ Prefer not to answer

Diagnosed disability(ies): _____

Medical Conditions: _____

Medications:

Name	Dosage	Administration schedule	Purpose

With whom do you live?

Name (first, last): _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Email: _____

Relationship: _____ Family member (describe: _____) _____ Spouse

_____ Residential provider _____ Other (describe: _____)

Emergency contact:

Name (first, last): _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Email: _____

Relationship: _____

Secondary emergency contact:

Name (first, last): _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Email: _____

Relationship: _____

Family doctor:

Name (first, last): _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Psychiatrist:

Name (first, last): _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Psychologist/therapist:

Name (first, last): _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Specialist doctor:

Name (first, last): _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Other Agency Involvement:

OVR Counselor name (first, last): _____

Supports Coordinator name (first, last): _____

Advocate name (first, last): _____

Other community provider name (first, last): _____

High School Attended:

Name of school: _____

Dates of attendance: _____ Graduated: _____ Yes _____ No

Benefits Amount per Month:

SSI: _____ SSDI: _____ Worker's compensation: _____ Unemployment: _____

Were you ever convicted of a felony? _____ Yes (provide details below) _____ No

Other Information:

Please list any other information important to know to serve you in the best manner.

Work History:

Employer: _____

Position name/description of work duties: _____

Start date: _____ End Date: _____

Reason for leaving: _____

Employer: _____

Position name/description of work duties: _____

Start date: _____ End Date: _____

Reason for leaving: _____

Employer: _____

Position name/description of work duties: _____

Start date: _____ End Date: _____

Reason for leaving: _____

Employer: _____

Position name/description of work duties: _____

Start date: _____ End Date: _____

Reason for leaving: _____

Employer: _____

Position name/description of work duties: _____

Start date: _____ End Date: _____

Reason for leaving: _____

For Easterseals use only	
Intake date:	
Employee completing intake:	
Referral source:	
Referred service:	

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Image Release Authorization

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I acknowledge that Easterseals Eastern Pennsylvania is authorized to use and share my image(s). I hereby release Easterseals Eastern Pennsylvania and its officers from any legal responsibility or liability for disclosure of the image(s).

_____

Please PRINT the name of the person whose image is being taken. Date

_____

Signature of person whose image is being taken (must be 18 years of age or older).

_____

Signature of parent or guardian if the image is of a minor (i.e., the child is under 18 years of age).

_____

Please PRINT the name of the above parent or guardian. Date

Please return this form to Easterseals in person or by mail, fax or email.
Call with any questions.

Phone: 610-289-0114 ext. 225
Fax: 610-289-4282
Email: cfeichtel@esep.org