

Wayfinders Application

To ensure that the application is processed, applicant and/or parent/guardian must complete all information. (Race & ethnicity tracking section is optional.)

First time application Last application submitted for Fall of 20____

Date you attended a Program Preview: _____

IDENTIFYING INFORMATION									
Applicant Name:					Birth date:				
Street Address:							Age:		
City:			State:		Zip Code:				
Phone: ()		Applicant's Cell Phone: ()		Female <input type="checkbox"/>		Male <input type="checkbox"/>			
Applicant's Email Address:			CA Drivers License:			Yes <input type="checkbox"/>		No <input type="checkbox"/>	
U. S. Citizen:		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Country of Citizenship:			
Languages Spoken in the Home:									
Are you Conserved:		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Areas Conserved:			
Conservator's Name:				Relationship to Applicant:					
PARENT INFORMATION									
Parent #1 or Guardian Name:									
Address:									
Primary Phone #:		()			Cell Phone #:		()		
Email Address:									
Parent #2 Name:									
Address:									

Primary Phone #:	()	Cell Phone #:	()
Email Address:			
SIBLING(S) INFORMATION			
Name of Sibling(s)		Age	Lives at Home
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
EDUCATION & SERVICES			
Name of High School Attended/Attending:			
Address:			
Phone #:	()	Fax #:	()
Contact Person:			Phone #: ()
Email:			H.S. Completion or Projected Date:
Indicate the approximate grade level for the following skills:			
Math: _____ Reading: _____ Writing: _____			
Name of College or Program Currently Attending:			
Address:			
Contact Person & Title:			
Phone #:	()	Fax #:	()
Email:			
Regional Center Client:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of RC:	
Address:			
Service Coordinator Name:			Fax #: ()
Phone #:	()	Email:	

In Home Support Services Client:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
IHSS Agency Name:			
Address:			
Contact Person & Title:		Fax #:	()
Phone #:	()	Email:	
Client of California Department of Rehabilitation:		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Process	
Address:			
DOR Counselor Name:		Phone #:	()
Email:		Fax #:	()
Do You Receive SSI:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Process <input type="checkbox"/> Will apply at 18		
If Yes, Name of Payee:		Amount Per Month:	\$
VOLUNTEER & COMMUNITY SERVICE			
Organization	Description of Activity & Duties	Hrs Per Week	
WORK EXPERIENCE			
Business/Organization	Duties	Dates Employed	Hrs/Wk

MEDICATION INFORMATION

Do You Take Medication(s): Yes No

Needs Assistance With Medications: Yes No If yes, please explain:

Medication(s)	Times of Day/Week	Purpose

PHYSICAL SUPPORTS

	Yes	No
Uses Manual Wheelchair		
Uses Electric Wheelchair		

Uses a Walker		
Uses a Cane		
Uses Handrails in Bathroom & Shower		
Requires Other Supports. If yes, please specify:		
BEHAVIOR		
	Yes	No
Caused property damage including starting fires		
Physically threatened and/or attacked others		
Verbally threatened others		
Self-injurious behavior		
Mistreating animals		
Elopement		
Lying		
Fabrication		
Inappropriate sexual behaviors		
Stealing		
Prior arrest or probation		
Current gang behavior, affiliation and desires		
Incontinence problems		
Requires attendant care		
If yes to any of the behavioral and/or self care issues, please explain in detail. Include the most recent date(s) of the occurrence(s) and severity (use another sheet for more writing space):		

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Which of the following best describes your drinking (alcohol) habits (check all that apply):

Daily <input type="checkbox"/>	Weekly <input type="checkbox"/>	Weekends Only <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Celebrations <input type="checkbox"/>	Never <input type="checkbox"/>
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Which of the following best describes your smoking habits (check all that apply):

Daily <input type="checkbox"/>	Weekly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Never <input type="checkbox"/>
# of Cigarettes Smoked:	Daily: _____	Weekly: _____	Monthly: _____

RACE & ETHNICITY TRACKING

Optional

For purposes of data collection for the Wayfinders funding, please mark the box(es) that best describes the applicant's race/ethnicity category of which s/he identifies with:

<input type="checkbox"/> A	Asian or Pacific Islander: Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
<input type="checkbox"/> B	African American (not of Hispanic origin): Person having origins in any of the black ethnic groups.
<input type="checkbox"/> H	Hispanic: Persons having origins in any of the Mexican, Puerto Rican, Cuban, Central or South American or other Latin Cultures, regardless of ethnicity.
<input type="checkbox"/> I	Native American or Alaskan Native: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
<input type="checkbox"/> W	Caucasian (not of Hispanic origin): Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

I have completed this Wayfinders application truthfully and to the best of my knowledge all information is accurate.

Applicant or Parent/Guardian Signature: _____

Date: _____

**COMPLETED PACKET MAILED TO:
Wayfinders at California State University, Fresno
5240 N. Jackson, Room 205, M/S UC 116
Fresno, CA 93740
559.278.0390**