



**LEARN of Central New Jersey
Service Application**

**THIS PROGRAM IS SPECIFICALLY DEVELOPED TO
ASSIST PEOPLE WITH PSYCHIATRIC DISABILITIES TO SUCCEED IN SCHOOL**

Date: _____

Name

Date of Birth

Street Address

City County State Zip

Telephone () _____ Cell () _____

Email: _____

| | | | |
|--|--|-------------------------------------|--|
| <u>Emergency Contact, Address, and Phone #:</u> | | <u>Social Security # :</u> | |
| | | <u>DSM IV Codes Axis I:</u> | |
| | | <u>DSM IV Codes Axis II:</u> | |

Are you currently enrolled in college?
 No, when are you planning to return to school: _____

What steps have you taken to return to school: _____

Yes, where: _____ Area of study: _____

Income Source (check all that apply)

- Employment SSD SSI
 Other _____

Health Insurance (check all that apply)

- Private Medicaid Medicare
 Other _____

Average Monthly Income _____

Describe your current living situation:

- own home apartment shared housing temporary housing shelter/ homeless
 alone with significant other with family with friends
 Other _____

Describe your current means of transportation:

- own car shared car public transportation walk bicycle
 Other _____

II. Education History

Date when high school diploma or GED was obtained: _____

List all colleges, universities, & vocational schools attended with corresponding dates and reason for leaving:

| School and Major | Semesters/ Years Attended | Reason for Leaving |
|------------------|---------------------------|--------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List any degrees or professional certifications you have received:

Have you ever defaulted on a loan? Yes No

If yes, please explain.

Is there any legal history that would interfere with your education goals? Yes No

If yes, please explain.

Current reason(s) for returning to school/ career goals:

III. Collaborative Providers

Are you currently working with the Division of Vocational Rehabilitation (DVR)?

Yes No

Are you currently receiving services/support from the below list? Please indicate if they support your educational goals.

Partial Care Provider _____ Yes _____ No _____

PACT _____ Yes _____ No _____

Residential _____ Yes _____ No _____

Supported Employment _____ Yes _____ No _____

Self help _____ Yes _____ No _____

Please attach proof of diagnosis

IV. Resources

How will you get to school? Check all that apply:

- self family/friend public transportation other _____
 unsure

How will you finance school? Check all that apply:

- financial aid self pay scholarship family support DVR
 VA benefits Other _____ unsure

Do you have regular access to a computer?

- yes no

Where do you access the computer? I own a computer

Can you use the computer to complete your assignments?

- yes no not very well

Can you navigate the internet?

- yes no not very well

Do you have an email account?

- ___yes ___no

How did you hear about our services?

All of the above information is true to best of my knowledge.

Signature

Date

Thank you for completing the application for services. We appreciate your interest in our program. We will be in contact soon.

If you need assistance in completing the application, please call (908) 687-9666

Applications can be faxed to (908)248-9222 or dropped off or mailed to:

**LEARN of Central New Jersey
373 Clermont Terreace
Union, NJ 07083**