Application to the Peer Support Groups for ages 14-26

Background Information

Last Name
First Name
Middle Initial
Address: (Street, City, State, Zip)
Telephone:
Email:
Date of Birth:
Gender Identity/Preferred Pronouns:

Do have a Developmental Disability or receive services from OPWDD

Circle One: Yes or No. If yes, you may choose to explain below.
Do you need any accommodations to receive emails or mailings from The Center For Self Advocacy, Inc.? If yes, what kind? (Ex. Braille, large print, etc.)

Do you receive Medicaid Service Coordination to help you with transportation and other goals? If Yes, please provide their contact information Below.

Care Coordinator
Name: __________________________ Telephone: _______________________
Agency:
☐ Person Centered Services ☐ Prime Care

II. Medical and Accessibility Needs
Do you have any medical concerns that sometimes affect your ability to travel, and/or require emergency medical attention? If yes, please explain:

__________________________________________________________________
__________________________________________________________________

Do you require a Service Animal for Travel? If yes, what kind?

__________________________________________________________________

Are there any other accessibility or medical needs you wish to inform us about?

__________________________________________________________________
### III. Scheduling Information

**Please Give Schedule Availability:** (circle all that apply)

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- Morning ☐
- Early Afternoon ☐
- Late Afternoon ☐
- Evening ☐

Please explain anything specific to your schedule that may affect your best times for participation? This question is used to help develop the best possible schedule for you.

Additional Comments (optional)

Applicant Signature and Date: ____________________________  ___________