Path Forward of Kentucky
Adult Day Training Application
901 Lehman Avenue, Suite 7
Bowling Green, KY 42103
Office: (270) 599-0020
www.pathforwardky.com

Applicant's full name:________________________________ Preferred Name: ________________

Home Address: ____

Phone: _________________________ Email Address: ___________________________________

DOB: _________________ Gender: _____________ Adjudicated? Yes No Unsure

Parent/Guardian Information (if applicable)

Name(s): ____

Relationship to Applicant: _________________________ Phone Number: ___________________

Email: ____

Information About Applicant

Waiver/Payment Types: (circle one)

- ☐ Michelle P Waiver
- ☐ Supports for Community Living
- ☐ Private Pay

Case Manager/Support Broker (if applicable)

Name: __________________________________

Agency: ____

Phone/Email: ____

Highest Level of Education:

- ☐ H/S Certificate
- ☐ H/S Diploma Received
- ☐ Associates Degree
- ☐ Some College

What are your personal and professional goals for participating in the Key Academy Independent Living Skills Program? What do you hope to learn or accomplish through your involvement?
(Please use a separate piece of paper if needed.)

____

____

____

Have you had previous experience in an Adult Day Training program? _______Yes ________No

If yes, where and when?____

Have you had previous work or volunteer experience? _______Yes ________No

Are there accommodations or assistance that the applicant will require to fully participate in Key Academy programming? ______No _______Yes

Independence/Self Care		Behavioral/Emotional Support	
Mobility/Physical Access		Fine Motor Skills	
Communication/AAC Device		Social Skills	
Sensory Needs		Technology Access	

Are you motivated to learn about opportunities and services in the community?
_________Yes __________ No

What is your long-term independence goal?____

Are you willing to engage in social and leisure activities with peers? ______Yes ________No

Emergency Care Information

Please list the names of two persons who may be contacted in case of emergency:

Name:_____________________________Relationship:________________ Phone

___________________ Name:_____________________________Relationship:________________

Phone ___________________

Name of Physician: _______________________________ Telephone: __________________________

Will you require any medications between 9am - 1 pm? ______Yes ________No

If YES, please list medications (Including any rescue medications):
____

Transportation

Transportation will be provided by **Waiver/ Relative/ Friend /Public Transportation**

Name:____

Phone Number: _______________________________________

I attest that the above information is true to the best of my knowledge and would like to be considered for the KEY Academy Program.

__________________________________ __________________________________

Signature of Applicant & Date ***Parent/Guardian Signature & Date***

<u>**Waiver Participants:**</u>

In order to complete your application, PFK also needs the following:

- Plan of Care
- MAP 351
- Behavior Support Plan (if applicable)
- Last IEP/504 plan (if available)

<u>**Private Pay Participants:**</u>

Please attach any information that gives a clear background of your learning styles such as IEP, Psychological Evaluations, etc. that you would like our Admissions Team to review.

Application and supporting documents may be returned to Path Forward via email:
key@pathforwardky.com

If you need assistance with obtaining documents to submit with your application, please contact us! At (502) 296-5624