INDEPENDENT LIVING PROGRAM APPLICATION

APPLICANT INFORMATION

Name:		
Date of birth: Age:	SSN: - -	Phone #:
Gender:	Race/ Ethnicity: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other:	
Current address:	Please Circle: HUD SECT8 SHELTER OTHER:	
City:	State:	ZIP Code:
Own Rent *(Please circle)*	Monthly rental payment:	County:
Names and Ages of Adults in the Household:		
Names and Ages of Children in the Household:		

EMPLOYMENT/ STUDENT INFORMATION/INCOME/INSURANCE INFORMATION

☐ Employed Employer:

☐ Unemployed ☐ Student ☐ Disabled ☐ No Income

Employer:					How long?
Position:			Hourly Salary *(please circle)*		Monthly Income:
SSDI: $	SSI: $	SSA: $	Child Support: $	Unemployment: $	SNAP ASSISTANCE: $
Families First: $	Other Adult Income: $				
Do you have a payee? ☐ Yes ☐ No					
Insurance: ☐ TNCARE ☐ Safety net ☐ Medicare ☐ Private Insurance ☐ No Insurance					

MENTAL HEALTH INFORMATION

Agency:	Services Received:	Duration of Treatment:
Last Appointment:	Service Provider:	Phone #:
Care Coordinator:	Phone #:	Location:

REQUEST FOR ASSISTANCE

Assistance needed for: ☐ Utilities ☐ Rent/Deposit ☐ Glasses ☐ Dentures ☐ Bus Pass (Peninsula clients only)	
Name of Utility Company if Assistance with Utilities:	
Name of Property if Assistance with Rent/Deposit:	
Amount of Assistance Needed: $	Plan for Next Payment:

SIGNATURES

*I authorize the verification of the information provided on this form is correct to the best of my knowledge.

Signature of Client/Guardian:	Date:
Signature of ILP Coordinator:	Date:

Applicant Checklist

The applicant is required to provide the following documents before an application is reviewed. The sooner these documents are provided, the sooner the application will be reviewed.

□ Copy of Identification
    □ State ID

□ Proof of income/employment/student
    □ At least two pay stubs, or
    □ Social Security or disability award letter, or
    □ Proof of student status, if applicable

□ Proof of engagement in mental health services
    □ Letter from agency
    □ Medical record from agency

□ Vendor Application (if required)
    □

□ Invoice/bill from agency being paid

Once all documents are ready, please contact 865-970-9800 to schedule a face-to-face appointment with a member of our staff.

Dear Patient:

Date:_____

Please take a couple of minutes to fill out this survey. **It is our mission to provide excellent care to our patients. Your evaluation and suggestions can help us continuously improve our services.** You do not need to put your name on the survey. Please return your completed survey to the Customer Service Representative at the front desk. Thank you.

PENINSULA OUTPATIENT CUSTOMER SERVICE SURVEY
INDEPENDENT LIVING PROGRAM

Which **PROVIDER(S)** did you see in the Clinic today? _____

1. Overall how would you rate the services you have received?

   1 – Poor 2 – Fair 3 – Good 4 – Very Good 5 – Excellent

If you did not rate us as Excellent, what could we do to get an Excellent rating?

2. How would you rate the front office staff (receptionist) on being polite and professional?

   1 – Poor 2 – Fair 3 – Good 4 – Very Good 5 – Excellent

3. When you call us on the telephone, how would you rate us on being polite and professional?

   1 – Poor 2 – Fair 3 – Good 4 – Very Good 5 – Excellent

4. How would you rate your provider's instructions or explanations of your treatment?

   1 – Poor 2 – Fair 3 – Good 4 – Very Good 5 – Excellent

5. How would you rate your provider's understanding and caring?

   1 – Poor 2 – Fair 3 – Good 4 – Very Good 5 – Excellent

6. How would you rate the teamwork between the staff members?

   1 – Poor 2 – Fair 3 – Good 4 – Very Good 5 – Excellent

7. On a scale of 1-10, how likely would you be to recommend Peninsula Outpatient to friends or relatives?

   Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent

8. Are there any improvements you would like to suggest about the safety of the care, treatment or services provided?

We want to provide EXCELLENT Customer Service.

If you would like to discuss this survey,
please provide us with your name and a phone number where you can be reached.

Name:_____ Phone #: _____

Thank you!

Mary Nelle Osborne, Ed.D.- Manager of Recovery Services

I acknowledge that I have been given a copy of the Peninsula Outpatient Customer Service Survey for the Independent Living Program. I understand that I may complete this, and return this form by fax, email, or in person to any of the contact methods listed for Peninsula Outpatient Clinics.

Signature

Date

Independent Living Program
1451 Dowell Springs Blvd
Knoxville, Tn 37909
865-970-9800 phone
865-374-7317 fax
PeninsulaILP@CovHlth.com email