APPLICATION FOR RESIDENTIAL AND/OR DAY SERVICES

INSTRUCTIONS: Answer as completely as possible. If it does not apply, write NA, if there is none, write none. Please *do not* leave any lines blank. If there is not enough room on the form to explain please feel free to attach another sheet of paper.

Date: _____

I. **Identifying Information**:

Name:_____
(First) (Middle) (Last) (Nickname)

Current Address: _____
(Street) (City) (County) (State) (Zip)

Permanent Address: _____
(Street) (City) (County) (State) (Zip)

Telephone Number _____ Social Security Number _____

Date of Birth _____ Place of Birth _____
(City) (County) (State)

Age _____ Sex _____ Height _____ Weight _____ Color of Hair _____Color of Eyes _____

Marital Status: Single____ Married ____ Dependents _____ Race _____

Citizenship Status _____

Actively Involved in Church: ___No ___Yes Religion/Church Preference: _____

Baptized: Yes ___ No___ Where & Date: _____ _____/_____/_____

Confirmed: Yes ___ No___ Where & Date: _____ _____/_____/_____

Primary Disability _____

Secondary Disabilities _____

DSM IV Diagnosis _____

Ambulatory: Yes ____ No _____ Identifying Marks _____

Language Spoken or Understood _____

Does applicant have a ND Photo Identification Card: Yes _____ No _____

Person to Contact in Case of an Emergency _____

Address _____
(Street) (City) (County) (State) (Zip)

Telephone Number: (Home) _____ (Work) _____

Other family members and other *supportive people* in applicant's life: (All siblings, teachers, friends, other relatives – please explain relationship.)

First Name Last Name	Relationship	Address	Telephone

II. <u>Family:</u>

Parents Name _____ Home Phone # _____

Address _____
(Street) (City) (State) (Zip)

Mother's Maiden Name _____

Birthdate of Father _____ Birthdate of Mother _____

III. Family Cont.

Birthplace of Father: City _____ State: _____

Birthplace of Mother : City _____State: _____

Father's Employer _____ Business Phone_____

Mother's Employer _____ Business Phone _____

Are parents separated: Yes___ No___ Divorced: Yes___ No___

Is father deceased: Yes___ No___ Is mother deceased: Yes___ No___

IV. Guardianship

Has the applicant been adjudicated incompetent Yes___ No___ If yes, a copy of adjudication papers must be enclosed.

Legal Guardian(s) Name: _____

_____

(Address) (County) (Phone)

Name: _____

_____

(Address) (County) (Phone)

Full Guardianship: Yes___ No___ Limited Guardianship: Yes___ No___
Conservatorship: Yes___ No___

If limited, list what areas: _____

_____

Where did guardianship action occur? _____

What date did guardianship or conservatorship action occur? _____/_____/_____

Does applicant have an advocate? Yes___ No___

Is applicant a ward of Grafton Developmental Center? Yes___ No___

If yes, what date did wardship occur? _____

V. Referral Source:

Name and addresses of agencies, schools, or institutions referring applicant for services.

Name	Agency	Address	Phone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Agencies Involved _____

_____

VI. Service Needs

Does applicant have housing available at the present time? _____

If yes, Name: _____ Address: _____

If no, who will make arrangements _____

What type of residential services does the applicant need? _____

What type of Day Programming does the applicant need? _____

VII. Educational History

What schools has applicant attend:	During what years?	Reason for leaving?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle last school grade attended: K 1 2 3 4 5 6 7 8 9 10 11 12

Did the applicant receive Special Education Services or attend Regular Education Classes?

_____

Can the applicant read? Yes_____ No _____ Level _____

Can the applicant write? Yes_____ No _____ Level _____

Can the applicant: Tell time Yes _____ No ____ Count by ones Yes ____ No _____
Count coins Yes _____ No _____

VIII. Work History

Has the applicant ever been employed? Yes _____ No _____
If yes, please list employers:

_____
(Name of last employer) (Address) (Dates employed)

_____
(Type of Work) (Reason for Leaving)

_____
(Name of previous employer) (Address) (Dates employed)

_____
(Type of Work) (Reason for Leaving)

What type of work does the applicant desire: _____

IX. History of Treatment and Training:

List clinics, schools, mental health centers, public and/or private hospitals, adjustment training centers, and other facilities where applicant has received treatment, evaluation, or training.

Dates: From	To	Places and Address	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the applicant ever had a vocational evaluation? Yes _____ No _____ Date _____

Age of onset of disability _____ Describe: _____

_____

_____

_____

Reason for application for services _____

_____

_____

_____

_____

_____

_____

_____

SKILLS CHECKLIST

Please check items which best describes applicants skills.

	Consistently	Sometimes	Never	Comments
Eating: Needs to be fed				
Throws or plays with food				
Eats with fingers				
Uses cup or glass				
Eats with spoon				
Eats with fork				
Uses knife for spreading				
Uses knife for cutting				
Eats slowly				
Eats rapidly				
Fussy eater				
Enjoys eating				
Shows good table manners				
Completely independent at mealtime				
Other				
Dressing: Needs to be dressed completely				
Resists dressing				
Assists in dressing				
Tries to dress self				
Puts on most clothing				
Buttons clothes				
Ties shoes				
Chooses own clothing				
Completely independent in dressing				
Other				

	Consistently	Sometimes	Never	Comments
Grooming: Needs complete help				
Washes hands				
Washes face				
Brushes teeth				
Combs or brushes hair				
Bathes self with supervision				
Bathes self independently				
Shaves				
Shampoos hair				
Completely independent in grooming				
Toileting: Diapered				
Scheduled toileting				
Can indicate need				
Soils during the day/night (specify)				
Wets during the day/night (specify)				
Cares for self at toilet				
Communications: Does not understand language				
Communicates with gestures only				
Communicates by signing				
Speaks single words				
Uses phrases				
Uses sentences				
Relates experiences				
Speech is easily understood				

	Consistently	Sometimes	Never	Comments
Communication cont. Speaks freely				
Speaks incessantly				
Follows simple directions				
Answers questions				
Converses spontaneously				
Talks on telephone				
Prints				
Writes				
Social Relations: Needs close supervision				
Accepts supervision				
Relates better to others than to peers				
Avoids interaction with peers				
Enjoys interaction with peers				
Plays near, but not with others				
Disrupts group activities				
Makes close friends				
Has interest in heterosexual relations				
Has interest in homosexual relations				
Chores and Activities: Helps with minor household tasks				
Goes about the neighborhood without supervision				
Makes purchases				
Does jobs around the neighborhood				
Uses public transportation				

Please list other skills: _____ None presently known___

Please list applicant's hobbies, leisure interests, and any social activities they have an interest in: _____

BEHAVIOR INFORMATION

	Check if answer is yes	Comments
Is hyperactive		
Is aggressive		
Is withdrawn		
Is depressed		
Has excessive habits (i.e. smoking)		
Uses disruptive noises		
Uses self-stimulation (i.e. rocking, hand flapping, etc.)		
Engages in self-injurious behaviors		
Others		

Please describe any formal behavior programs utilized in the past, whether successful or unsuccessful:

_____

_____

_____

_____

If applicant is currently on a formal behavior program, please attach a copy of that program to this application.

X. Applicant's Financial Information

Applicants Monthly Income: Current Amount

Social Security _____

Supplemental Security (SSI) _____

Aid to Dependent Children (AFDC) _____

Work Income _____

Family _____

Food Stamps _____

Housing Assistance _____

Miscellaneous (circle all that apply) _____
(Insurance, Railroad Retirement, Vet Adm, BIA, G.A., etc)

If applicant is not receiving Social Security or SSI, please explain: _____

_____

Social Security Information:

Date of Application _____ Date of Rejection _____

Date of Appeal _____ Accepted/Rejected Date _____

Applicant Resources: If yes: Account Number and Where Located

	Yes	No	
Trust Account	( )	( )	_____
Checking Account	( )	( )	_____
Savings Account	( )	( )	_____
Burial Account	( )	( )	_____
Certificates of Deposits	( )	( )	_____
Savings Bonds	( )	( )	_____
Life Insurance	( )	( )	_____

Miscellaneous _____

Does applicant have a representative payee for any of the above? Yes___ No___ Please indicate.

Name of Payee _____

Address _____ Phone _____

Medical Insurance Information:

Covered by Medical Assistance: Yes _____ County _____

MA # _____

Date accepted ____/_____/_____

No _____

If not, has it been applied for? Yes _____ No _____

If yes, date applied ____/____/____

County applied to: _____

Covered by Medicare? Yes _____ Medicare # _____

Date accepted____/_____/_____

No _____

If no, has it been applied for? Yes _____ No _____

If yes, date applied for ____/_____/_____

Private Medical Insurance? Yes _____ Company: _____

Address: _____

_____

Policy number: _____

No _____

Signature of individual completing form: _____

_____

(Title or Relationship to the applicant)

Address _____ Phone _____ Date _____

Applicant's Signature _____ Date _____

XI. LIST OF PHYSICIANS

1. Current Physician _____ Date of last exam _____

   Address _____ Date of last physical _____

   City _____ State _____ Zip _____ Phone Number _____

2. Current Dentist _____ Date of last exam _____

   Address _____ Dentures: Yes ( ) No ( )

   City _____State _____ Zip _____ Phone Number _____

3. Current Ear Doctor _____ Date of last exam _____

   Address _____ Hearing Aid: Yes ( ) No ( )

   City _____ State _____ Zip _____ Phone Number _____

4. Current Eye Doctor _____ Date of last exam _____

   Address _____ Glasses: Yes ( ) No ( )

   City _____ State _____ Zip _____ Phone Number _____

5. Current Neurologist _____ Date of last exam _____

   Address _____ Seizures: Yes ( ) No ( )

   City _____ State _____ Zip _____ Phone Number _____

6. Current Psychiatrist _____ Date of last appt. _____

   Address _____ Date of next appt. _____

   City _____ State _____ Zip _____ Phone Number _____

7. Other Specialists_____ Phone Number _____

   Other Specialists _____ Phone Number _____

XII. CURRENT MEDICATIONS

NAME	DOSAGE	FREQUENCY	REASON FOR MED

Date of last lab work _____

Laboratory procedure complete _____

Results _____

Does the applicant require assistance with administering medication? Yes _____ No _____

If yes, explain: _____

_____

**** A copy of any current medication prescription orders must accompany individual at the time of admission.***

XIII. ALLERGIES

Is applicant allergic to:

A. Medication?

Yes ( ) No ( ) Please list _____ Type of reaction _____

_____ _____

_____ _____

B. Food?

Yes ( ) No ( ) Please list _____ Type of reaction _____

_____ _____

_____ _____

C. Other?

Yes ( ) No ( ) Please list _____ Type of reaction _____

_____ _____

_____ _____

XIV. DIET

Is applicant on a special diet as ordered by a medical doctor? Yes _____ No ___ x ____

Date started _____ Type of diet _____ Reason for diet _____

Doctor's Name _____ Address _____ Phone _____

XV. ACTIVITY

2. List all activities or limitations applicant is restricted from as ordered by a medical doctor:

_____

_____

A copy of doctor's orders must accompany applicant upon admission.

2. Does applicant have any physical limitations that require the use of special devices? (wheelchair, braces, Walker, orthopedic shoes, splints, canes, etc.) Please list _____

_____

Describe use: _____

_____

XVI. MEDICAL HISTORY

In addition to the following information, please enclose all past medical history information with this document.

1. **Developmental History:**

List any problems during pregnancy & birth: _____

_____

Birth weight _____ Length at birth _____

Milestones: Crawled at_____ Walked at_____ Talked at_____ Toilet trained at_____ (list by years or months)

2. **List all previous hospitalizations** (operations/injuries/other) and ongoing medical care.

Date	Nature of Hospitalization/Medical Care	Name and Address of Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List past illnesses: (month and year) _____

_____

_____

_____

Is applicant Prone to any of the following? (Please check if yes)

Constipation _____ Nose Bleeds _____ Strep Throat _____ Weight Gain _____ Asthma _____

Diarrhea _____ Colds _____ Vaginal Infections _____ Urinary Tract Infections (Bladder) _____

Does the applicant have a seizure disorder? Yes _____ No _____ Age of onset _____

Date of last seizure _____ Type of Seizures _____

Average number of seizures per month _____

Hepatitis B Status: Immune _____ Susceptible _____ Carrier _____ Unknown _____

4. Immunization Records: ***Please attach or forward a copy of all immunizations****

Last Mantoux _____

Has the applicant ever had a positive TB test? Yes _____ No _____

Last Chest X-ray _____ Last Tetanus shot _____

5. Other

Age menstruation began _____ Date of last menstrual cycle _____

Does the applicant have regular monthly menstrual cycles? Yes _____ No _____

If no, please comment: _____

Has the applicant ever used birth control? Yes _____ No _____ Method _____

Date started _____ Date discontinued if applicable _____

Has the applicant ever been sterilized? Yes _____ No _____ Method _____

Date _____

Signature of individual completing Medical History Form: _____
(Title or Relationship to the Applicant)

Address _____ Phone _____ Date _____