Application for Residential Services

Check for which program applying for:

□ Elmwood (Chesterfield) □ Bonnie (Stuarts Draft) □ Tate (Ashland)
□ MacLeigh (VA Beach) □Garber Morris (Varina)
□ Mary Beth Graff (Varina) □ Lynchburg

Applicant Information

Last Name:	First Name:	Middle:	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:
Phone:	Social Security Number:	Sex: □ Male □ Female	
Date of Birth:	Birth Place:	Marital Status:	
Height:	Weight:	Eye Color:	Hair Color:
Other Identifying Features (birth marks, scars, etc.):		Race:	
Religious Preference:			

Parent Information

Mother's Name:			
Street Address:	City:	State:	Zip Code:
(Day) Phone:	(Evening) Phone:		
Father's Name:			
Street Address:	City:	State:	Zip Code:
(Day) Phone:	(Evening) Phone:		

Emergency Contact Information

Name:			
Street Address:	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:

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(Day) Phone:	(Evening) Phone:	Relationship:	
Name:			
Street Address:	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:
(Day) Phone:	(Evening) Phone:	Relationship:	

Legal Guardian/ Legally Authorized Representative
Does the applicant have a court appointed Guardian? □ Yes □ No
Does the applicant have a Legally Authorized Representative? □ Yes □ No

DOCUMENTATION MUST BE ATTACHED

Name:			
Street Address:	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:
(Day) Phone:	(Evening) Phone:	Relationship:	

Criminal History
Does the applicant have a criminal record? □ Yes □ No

State/County:
Offenses (include dates):
Services/ Conditions mandated by the court:

Financial Resources
Please list current account balances and any trust or cash available including checking, savings, or financial aid or loans applied for.

Type of Account	Establishment Name and Location	Balance
Checking		
Savings		
Trust		
Burial Plan *(please attach copy)*		

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Income Sources

Source	Monthly Amount	Date Applied (if not yet receiving)
SSI		
Social Security		
Pay Check		
Food Stamps		
Auxiliary Grant		
Other (specify): (e.g. railroad retirement, child support, veteran's benefits, worker's compensation, unemployment, public assistance)		
Other (specify):		

Representative Payee

Name:				
Street Address:	City:	State:	Zip Code:	
Mailing Address (if different):	City:	State:	Zip Code:	
(Day) Phone:	(Evening) Phone:			

Health Insurance

ATTACH COPIES OF INSURANCE CARDS

Coverage	Name Provider / Carrier (Medical, Dental, Mental Health)	Group No / Policy #
Medicaid		
Medicare	□ Part A □ Part B □ Part D Insurance Company:	
Other:		
Community Living Waiver	Yes or No	Effective Date

Current Living Situation

Who is your primary caregiver(s)? Relationship?
With whom do you live with?
Please describe the reason for this referral. Be as specific as possible.

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Agency Involvements

Community Service Board:	Support Coordinator:	Phone: Fax:	
Mailing Address:	City:	State:	Zip Code:

Social Services:	Eligibility Worker:	Phone: Fax:	
Mailing Address:	City:	State:	Zip Code:

Does the applicant currently participate in
□ Yes □ No
If yes, please provide the following information:

Name of Agency:	Contact Person:	Phone: Fax:	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:

Name of Agency:	Contact Person:	Phone: Fax:	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:

Name of Agency:	Contact Person:	Phone: Fax:	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:

Education
Has the applicant attended school? □ Yes □ No
How many years attended. _____
If yes, what was the name and address of last school attended? _____
_____

Did the applicant graduate? □ Yes □ No
If yes, what type of degree did they receive? _____

Disabilities

ATTACH MOST RECENT PSYCHOLOGCIAL EVALUATION

Condition	Briefly Describe Current Function and Support
Developmental Disability	
Cerebral Palsy	
Autism	
Down Syndrome	
Motor Issues	

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Communication	
Vision Impaired	
Hearing Issues	
Mental Health	
Other:	
Other:	

Abilities and Behavior

How do you communicate with others?

□ Speaks clearly
□ Difficult to understand
□ Cannot speak, but understands others
□ Uses gestures to communicate
□ Uses facial expressions t communicate
□ Uses sign language
□ Uses a communication device
□ Other (specify): _____

Describe assistance needed: _____
_____
_____

How do you get around?

□ Walks
□ Walks with assistance
□ Walks with other supports (e.g. braces, walker cane)
□ Uses a wheelchair some of the time
□ Uses a wheelchair all of the time
□ Other (specify): _____

Describe assistance needed: _____
_____
_____

How much assistance do you need during the following personal care activities?

- Dressing

□ Total Assistance
□ Some Assistance (describe):_____
□ Independent
□ Other (specify): _____

Describe assistance needed: _____
_____
_____

- Bathing

□ Total Assistance
□ Some Assistance (describe): _____
□ Independent
□ Other (specify): _____

Describe assistance needed: _____
_____
_____

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- Eating

□ Total Assistance
□ Some Assistance (describe): _____
□ Independent
□ Other (specify): _____
Describe assistance needed: _____
_____
_____

- Toileting

□ Total Assistance
□ Some Assistance (describe): _____
□ Independent
□ Other (specify): _____

Describe assistance needed: _____
_____
_____

Does the applicant use any adaptive equipment?

□ Wheelchair
□ Walker
□ Gait Belt
□ Lift
□ Other (specify): _____

□ Cane
□ Feeding Tube
□ Positioning Equipment
□ Adaptive Utensils

Does the applicant sleep through the night? □ Yes □ No
If no, please explain: _____
_____
_____

Does the applicant exhibit any behavior concerns (including stereotyped behaviors)? □ Yes □ No
Describe: _____
_____
_____
_____
How often does this occur?
_____ per day
_____ per week
_____ per month
Other: _____

Describe the level of supervision the applicant requires at home and in the community: _____
_____
_____
_____
_____
_____

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Medical References

Has the applicant ever been admitted to a psychiatric hospital or facility for persons with a Developmental Disability? □ Yes □ No

If yes, please give name(s) of the institution(s) and date(s) of residency:

_____

_____

_____

_____

Primary Care Physician:		Phone: Fax:	
Street Address:	City:	State:	Zip Code:

Dentist:		Phone: Fax:	
Street Address:	City:	State:	Zip Code:

Pharmacy:		Phone: Fax:	
Street Address:	City:	State:	Zip Code:

Specialist:	Specialty:	Phone: Fax:	
Street Address:	City:	State:	Zip Code:

Specialist:	Specialty:	Phone: Fax:	
Street Address:	City:	State:	Zip Code:

Specialist:	Specialty:	Phone: Fax:	
Street Address:	City:	State:	Zip Code:

Has the applicant participated in physical therapy? □ Yes □ No

If yes, please describe the outcome: _____

_____

_____

Has the applicant participated in occupational therapy? □ Yes □ No

If yes, please describe the outcome: _____

_____

_____

Has the applicant participated in speech therapy? □ Yes □ No

If yes, please describe the outcome: _____

_____

_____

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Medications

Does the applicant require assistance with medication management? □ Yes □ No

If yes, please describe assistance needed: _____

_____

_____

_____

Please list all medication currently taking. Include over the counter and as needed medications as well. Attach additional sheets if necessary.

Medication Name	Dosage	Reason	Prescribing MD	Phone # of MD	When first prescribed

Allergies

Please list any allergies the applicant has. Include allergen and reaction.

Allergy	Reaction

Adverse Drug Effects

Please list any adverse drug effects. Include medication name and reaction.

Drug	Reaction

Previous Medications

Please list any previously taken psychotropic medications and reason it was discontinued.

Medication	Reason it was discontinued

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Medical History Information

Does the applicant have an Advance Medical Directive or a Do No Resuscitate order?
□ Yes □ No

PLEASE ATTACH THIS ORDER, IF PRESENT

Has the applicant had any of the following? (Give age)

Red Measles		Meningitis		Pneumonia	
Whooping Cough		Rheumatic Fever		Mumps	
German Measles		Bronchitis		Diphtheria	
Encephalitis		Severe Diarrhea		Jaundice	
Chicken Pox		Poliomyelitis		Hepatitis	
Scarlet Fever		Tuberculosis		HIV/AIDS	

ATTACH IMMUNIAZTION RECORDS

Has the applicant ever been hospitalized? □ Yes □ No
If yes, please indicate why, at what age, the name and address of the hospital and attending physician:
_____
_____
_____
_____

Has the applicant ever had a serious accident or injury? □ Yes □ No
If yes, please explain: _____
_____
_____
_____

Has the applicant had any surgeries? □ Yes □ No
If yes, please indicate reason, age, name and address of hospital, and attending physician:
_____
_____
_____
_____

Has the applicant ever had seizures? □ Yes □ No
If yes, what age did this occur? _____

Has the applicant continued to have seizures? □Yes □No
If yes, how frequent? _____
Please describe seizure activity (e.g. length, grand mal, petite mal, etc.) and behavior afterward:
_____
_____
_____
_____

Does the applicant have a special diet prescribed by a physician? □ Yes □ No
If yes, please describe the specifications of the diet:
_____
_____
_____

Does the applicant need special foods or food prepared in a special way? □ Yes □ No

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If yes, please describe: _____
_____
_____

Has the applicant been diagnosed with diabetes or hypoglycemia? □ Yes □ No
If yes, please indicate the type of diabetes: □ Type I □ Type II
How often is blood sugar checked? _____
How is blood sugar controlled?
_____
_____
_____

Name of physician being seen for this condition: _____

Does the applicant have any ongoing medical health care needs or physician ordered medical procedures (e.g. blood work, lab tests, etc.)? □ Yes □ No
If yes, please describe procedure, frequency, and physician name: _____
_____
_____
_____
_____

Does the applicant have a medical condition which requires procedures to be performed only by a nurse (e.g. changing a feeding tube, giving a shot)? □ Yes □ No
If yes, please indicate procedure: _____
_____
_____

Is the applicant able to identify and address with a physician medical needs?
□ Yes □ No
If yes, please describe assistance needed: _____
_____
_____
_____

Is the applicant able to make and maintain medical appointments (including utilizing transportation? □ Yes □ No
If yes, please describe assistance needed: _____
_____
_____
_____

Does the applicant have any medical conditions for which they are currently being treated? □ Yes □ No
If yes, please describe the condition, frequency of intervention, and physician name: _____
_____
_____
_____
_____
_____

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Has the applicant been sexually active? □ Yes □ No
If yes, please indicate what age the applicant began sexual activity: _____

Has the applicant been diagnosed with a venereal disease?
If yes, please indicate the disease and year it was diagnosed: _____
_____
_____

Does the applicant have any children? □ Yes □ No
If yes, please indicate their sex and age: _____

Is the applicant currently sexually active? □ Yes □ No

Personal Interests and Supports
What is the daily routine of the applicant?

What does the applicant enjoying doing? What is the applicant interested in? What is the applicant's likes and dislikes?

Are there any cultural or family issues the applicant would like Heart Havens, Inc. to know?

By signing below, I agree I have given true, correct and complete information.

Signature of person completing this application:	Relationship to applicant:
Name (print):	Date:

Signature of Applicant (or Legal Guardian or LAR):	
Name (print):	Date:

Signature of Heart Havens, Inc. representative:	Title:
Name (print):	Date: