



Application for Residential Services

Check for which program applying for:

- | | |
|--|---|
| <input type="checkbox"/> Macleigh/VA Beach | <input type="checkbox"/> Bonnie/Stuarts Draft |
| <input type="checkbox"/> Kilmarnock/Rappahanock | <input type="checkbox"/> Saratoga/Winchester |
| <input type="checkbox"/> Colonial Beach/Colonial Beach | <input type="checkbox"/> Tate/Ashland |
| <input type="checkbox"/> Lynchburg | <input type="checkbox"/> Mary Beth Graff/Varina |
| <input type="checkbox"/> Garber Morris/Varina | |

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: <input type="checkbox"/> Male <input type="checkbox"/> 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/Guardian 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:			

(cont.)



Application for Residential Services

Emergency Contact

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



Application for Residential Services

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 <i>(please attach copy)</i>		

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:		



Application for Residential Services

Health Insurance

ATTACH COPIES OF INSURANCE CARDS

Coverage	Name Provider / Carrier (Medical, Dental, Mental Health)	Group No / Policy #
Medicaid		
Medicare	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> 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.

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:



Application for Residential Services

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 PSYCHOLOGICAL EVALUATION

Condition	Briefly Describe Current Function and Support
Developmental Disability	
Cerebral Palsy	
Autism	
Down Syndrome	
Motor Issues	
Communication	
Vision Impaired	
Hearing Issues	
Mental Health	
Other:	
Other:	

Abilities and Behavior

How do you communicate with others?

Speaks clearly

Uses facial expressions to communicate

Difficult to understand

Uses sign language

Cannot speak, but understands others

Uses a communication device

Uses gestures to communicate

Other (specify): _____

Describe assistance needed: _____

How do you get around?

Walks

Uses a wheelchair some of the time

Walks with assistance

Uses a wheelchair all of the time

Walks with other supports (e.g. braces, walker, cane)

Other (specify): _____

Describe assistance needed: _____



Application for Residential Services

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: _____
- _____
- _____

• 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?

- | | |
|---|--|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Feeding Tube |
| <input type="checkbox"/> Gait Belt | <input type="checkbox"/> Positioning Equipment |
| <input type="checkbox"/> Lift | <input type="checkbox"/> Adaptive Utensils |
| <input type="checkbox"/> Other (specify): _____ | |

Does the applicant sleep through the night? Yes No

If no, please explain: _____



Application for Residential Services

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: _____

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:



Application for Residential Services

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: _____

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



Application for Residential Services

Previous Medications

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

<u>Medication</u>	<u>Reason it was discontinued</u>

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 IMMUNIAZION 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? _____



Application for Residential Services

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

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: _____



Application for Residential Services

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: _____

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?



Application for Residential Services

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

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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: