

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. Family:**

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

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

Age of onset of disability \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for application for services \_\_\_\_\_

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## SKILLS CHECKLIST

Please check items which best describes applicants skills.

	Consistently	Sometimes	Never	Comments
<b>Eating:</b> 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				
<b>Dressing:</b> 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
<b>Grooming:</b>				
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				
<b>Toileting:</b>				
Diapered				
Scheduled toileting				
Can indicate need				
Soils during the day/night (specify)				
Wets during the day/night (specify)				
Cares for self at toilet				
<b>Communications:</b>				
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
<b>Communication cont.</b>				
Speaks freely				
Speaks incessantly				
Follows simple directions				
Answers questions				
Converses spontaneously				
Talks on telephone				
Prints				
Writes				
<b>Social Relations:</b>				
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				
<b>Chores and Activities:</b>				
Helps with minor household tasks				
Goes about the neighborhood without supervision				
Makes purchases				
Does jobs around the neighborhood				
Uses public transportation				



**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:

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*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

Trust Account	Yes	No	
	( )	( )	_____

Checking Account	( )	( )	_____
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Savings Account	( )	( )	_____
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Burial Account	( )	( )	_____
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Certificates of Deposits	( )	( )	_____
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Savings Bonds	( )	( )	_____
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Life Insurance	( )	( )	_____
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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 _____



**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 \_\_\_\_\_