LifeSpan...A Community Service
PO Box 1978
Jackson, MI 49204-1978
Ph. 517-784-4426 Fax 517-784-2120
A 501 c 3 Nonprofit Housing Corporation

EQUAL HOUSING OPPORTUNITY

PICC Hillsdale | LifeChoices | HomeCare | DeForest Respite Home | Hope House | Fowler House | Rewards

ALL QUESTIONS MUST BE ANSWERED COMPLETELY

APPLICATION FOR RESIDENCE AT:

_____ HOPE HOUSE I, INC or _____HOPE HOUSE II, N.P.H.C./FOWLER HOUSE

Referred by: _____ Date Received: _____

Phone: _____ Time Received: _____

Applicant: _____
Last First Middle

Address: _____
Street City State Zip Code

Phone: _____ Date of Birth: _____ SS #: _____

Sex: _____Male _____Female Marital Status: _____Single _____ Married
_____ Widowed _____ Divorced _____# Children

Name of person completing this form, if other than Applicant: _____

_____

Relationship to Applicant: _____

Family Contact or next of kin: _____

Address: _____

Phone: _____ Alternate Phone: _____

Is the Applicant his/her own guardian: _____ YES or _____ NO

If no, who is the court appointed guardian: _____

Address: _____

Phone: _____ Alternate Phone: _____

What is the type and scope of guardianship? _____

County of guardianship: _____

Who should be contacted in case of an emergency? _____

Address: _____

Phone: _____ Alternate Phone: _____

Placing Agency/Person: _____

Religious Preference: _____

Does Applicant have a driver's license? _____ YES or _____NO

Physical Disabilities and treating physician: (seizures, blindness, etc):

Disability	Treating Physician	Address	Phone	Date last seen

What is the nature of the Developmental Disability? Diagnosis: (Cerebral Palsy, Mental Retardation, etc.) _____

If M.R., please describe the level of disability with full scale IQ if known: (severe-20, IQ, moderate-45 IQ, mile-60 IQ)

Please give a brief description of the Applicant: (i.e. skills, interests, hobbies, personality, likes, dislikes, etc.)

FAMILY INFORMATION: Please list names of parents, brothers and sisters, and any other persons (or family members) you (the Applicant) have close contact with.

1. Name: _____ Age: _____

Address: _____

Phone: _____ Relationship: _____

2. Name: _____ Age: _____

Address: _____

Phone: _____ Relationship: _____

Family Involvement: _____
_____

Have you ever lived away from your parent's home for an extended period of time? _____yes or _____no if so, please fill in the following: (i.e. Adult Foster Care, Institution, other relative, etc.)

Location/Address: _____

Relationship: _____ Dates: _____

Location/Address: _____

Relationship: _____ Dates: _____

List states where you have lived _____

EDUCATIONAL AND VOCATIONAL DATA:

Are you currently participating in a day program or competitive employment? _____ YES or _____ NO if yes, where? Name: _____

Address: _____ Phone:_____

Do you have a high school diploma? _____ YES or _____ NO if yes, from where?
_____

List all of schools you have attended: (name of school, address, and dates attended)

1._____

2. _____

3. _____

List all activity programs or other special programs you have been involved in: (if none, please state "NONE")

1. Program: _____ Dates of Attendance: _____

Address: _____ Contact Person: _____

2. Program: _____ Dates of Attendance: _____

Address: _____ Contact Person: _____

3. Program: _____ Dates of Attendance: _____

Address: _____ Contact Person: _____

Have you ever been competitively employed? _____ YES or _____NO if yes, where?

1. Name of Company: _____ Supervisor: _____

Address: _____ Why left: _____

Responsibilities: _____
_____

2. Name of Company: _____ Supervisor: _____

Address: _____ Why left: _____

Responsibilities: _____
_____

MEDICAL/DENTAL/PSYCHOLOGICAL INFORMATION:

Who is your primary physician? Name: _____

Address: _____ Phone: _____

When was your last physical examination? Date: _____

If Applicant is female, does she have regular menstrual periods? _____YES or _____NO

Please list any difficulties, if any: _____

Do you (Applicant) have seizures? ____YES or ____NO Date of onset (if known) _____

What kind are they, how frequent? _____

Are they controlled with medications? _____YES or _____NO

Are you currently taking any medications? _____YES or _____NO if yes, specify medications, dosages, and reason for taking it:

_____

_____

_____

_____

What is the name of your current pharmacy? _____

Does, or has the Applicant administer his/her own medications? _____ YES or _____NO if not, who does? _____

Do you have any allergies? _____ YES or _____NO if yes, please list:

Type of allergy: _____ Treatment: _____

Type of allergy: _____ Treatment: _____

Type of allergy: _____ Treatment: _____

Is there a history of health problems (i.e. heart, diabetes) in your family? _____ YES or _____NO if yes, please list relationship to you and type of problem:

_____

_____

What hospital do you prefer using? Name: _____

Who is your dentist? Name: _____

Address: _____ Phone: _____

Do you have any serious dental problems? (i.e. dentures, gum disease) ____ YES or ____NO if yes, please explain:

_____

_____

Have you ever had a psychological examination? _____ YES or _____NO if yes, when? _____ By whom? _____

Address: _____ Phone: _____

Have you ever been treated for emotional or behavioral problems? _____ YES or _____NO if yes, please list doctors, hospitals, or agencies involved and dates of treatment:

_____

_____

Are you currently receiving any counseling? _____ YES or _____NO if yes, from whom?

Name: _____ Agency: _____

Address: _____ Phone: _____

Please list names and address of other physicians or medical sources having pertinent information about you:

Name: _____ Reason for contact: _____

Name: _____ Reason for contact: _____

Name: _____ Reason for contact: _____

In the event of a death, whereas the applicant's guardian or family can not be reached, the (name of funeral home) _____ should be used.

FINANCIAL INFORMATION: APPLICANT MUST BE WILLING TO ACCEPT SOCIAL SERVICES SUPPORT

Most of the residents currently living at Hope House I and II (Fowler House) are eligible to receive some type of financial assistance. It is important that we obtain the following information so that, if necessary, we can refer you to the appropriate agencies.

Do you receive SSI benefits? _____ YES or _____NO Amount: $_____

Payee: _____ Phone: _____

Address: _____

If not, have you ever applied? _____ YES or _____NO Date: _____

Do you receive SSA benefits? _____ YES or _____NO Amount: $_____

Payee: _____ Phone: _____

Address: _____

If not, have you ever applied? _____ YES or _____NO Date: _____
SSI Claim #: _____ SSA Claim #:_____

Do you have any property or receive additional benefits (trust fund, stocks, bonds, savings, checking, CD's pensions, etc.)? _____ YES or _____NO if yes, please list below:

Source (bank name, if applicable): _____
Amount: _____

Source (bank name, if applicable): _____
Amount: _____

Source (bank name, if applicable): _____
Amount: _____

Do you earn money from work that you do now? _____ YES or _____NO

Employer: _____ Supervisor: _____

Address: _____ Phone: _____

Who is ultimately responsible for you financially? (Please check one of the following):
_____Self _____Family _____Guardian _____Payee _____Other _____

Do you have any of the following insurance?

Medicaid _____ YES or _____NO if yes, Policy # _____

Medicare _____ YES or _____NO if yes, Policy # _____

Medical _____ YES or _____NO if yes, Policy # _____
Name of Company: _____

Dental _____ YES or _____NO if yes, Policy # _____
Name of Company: _____

Other _____ YES or _____NO if yes, Policy # _____
Name of Company: _____

Do you own or have access to any credit card or charge accounts? _____ YES or _____NO
If so, please specify: _____

Is this an emergency admission? _____ YES or _____NO if yes, please state reason: ____
_____

_____

1. Has the applicant been in trouble with the law or has exhibited behavior which would put him/her at risk for law enforcement? _____ YES or _____NO if yes please describe:
_____

_____

2. Has the applicant been a victim of or perpetrator of physical abuse?
_____ YES or _____NO if yes please describe: _____

_____

3. Has the applicant been a victim of or perpetrator of sexual abuse?
_____ YES or _____NO

4. Is the applicant subject to a lifetime state sex offender registration program in any state? : _____YES or _____NO

5. Has the applicant exhibited any behaviors which the staff should be made aware of?
_____ YES or _____NO if yes please describe: _____

ENTRY LEVEL CRITERIA FOR PLACEMENT

Check the most appropriate column

SKILL	CAN PERFORM	WITH ASSISTANCE	NOT ABLE TO
1. Takes care of personal hygiene on a Regular basis i.e. Monthly period	_____	_____	_____
Dental	_____	_____	_____
Hair	_____	_____	_____
Physical cleanliness	_____	_____	_____
2. Able to dress appropriately (for weather) and color coordination.	_____	_____	_____
3. Can request and/or schedule doctor appointments.	_____	_____	_____
4. Able to clean and organize own room.	_____	_____	_____
5. Able to perform basic housekeeping tasks. Dusting	_____	_____	_____
Vacuuming	_____	_____	_____
Mopping	_____	_____	_____
Organizing	_____	_____	_____
6. Can plan and cook a balanced meal.	_____	_____	_____
7. Can serve a meal.	_____	_____	_____
8. Able to verbally communicate.	_____	_____	_____
9. Can refill prescribed medications.	_____	_____	_____
10. Can set up and follow prescribed meds.	_____	_____	_____
11. Can use public transportation.	_____	_____	_____
12. Able to do laundry. Sort clothes	_____	_____	_____
Use washer/dryer	_____	_____	_____
13. Able to relate to: Peers	_____	_____	_____
Groups	_____	_____	_____
1 to 1	_____	_____	_____
14. Can participate in house activities.	_____	_____	_____
15. Able to manage leisure time.	_____	_____	_____
16. Can use the postal service.	_____	_____	_____
17. Can use phone and phone book.	_____	_____	_____
18. Recognizes money. Bills	_____	_____	_____
Coins	_____	_____	_____
19. Able to budget money.	_____	_____	_____

ENTRY LEVEL CRITERIA FOR PLACEMENT CONT.

	CAN PERFORM	WITH ASSISTANCE	NOT ABLE TO
20. Can use food stamps (card)	_____	_____	_____
21. Able to shop on his/her own.	_____	_____	_____
22. Has nutritional eating habits.	_____	_____	_____
23. If upset, handles self in proper manner.	_____	_____	_____
24. Able to accept positive criticism when administered by staff and/or peers.	_____	_____	_____
25. Able to express emotions.	_____	_____	_____
26. Able to communicate with people in community.	_____	_____	_____
27. Able to ask for and follow directions.	_____	_____	_____
28. Able to understand signs and symbols.	_____	_____	_____
29. Able to write own name.	_____	_____	_____
30. Knowledge of local social agencies.	_____	_____	_____
31. Able to feed themselves	_____	_____	_____

Comments: _____

_____

_____

_____

By signing below I attest that all information included in this application is accurate to the best of my knowledge and that any false information could result in the rejection of the application:

_____ _____

Signature **Date**

ADDENDUM TO CRITERIA FOR PLACEMENT

Name of Resident: _____

To be completed by the Resident or Resident's designated representative.

Please complete the following:	YES	NO	COMMENTS
1. Has resident set or attempted to set fires?	_____	_____	_____
2. Has resident hit or attempted to hit another person?	_____	_____	_____
3. Does resident have a history of self-abuse?	_____	_____	_____
4. Does resident have any susceptibility to hyperthermia?	_____	_____	_____
5. Does resident have any susceptibility to hypothermia?	_____	_____	_____
6. All resident-occupied rooms are heated at a temperature range of between 68 and 72 degrees Fahrenheit. Are any variations required in the resident's health care appraisal?	_____	_____	_____

7. Does resident require any special diets? _____

8. Is there any other information we should know about to safely protect the resident, other residents in the facility, or staff persons? If yes, please explain:_____

_____

_____

9. Has a guardian ever been appointed by a court for the resident? _____ Yes or _____No
If yes, please list (also attach copy of authority)

_____

Name Address Phone

10. Has a conservator been appointed by a court for the resident? _____ Yes or _____No
If yes, please list (also attach copy of authority)

_____

Name Address Phone

11. Has the resident signed a durable power of attorney or appointed a Designated Representative? _____ Yes or _____No If yes, please list (also attach copy of authority)

_____

Name Address Phone

Name of person filling out this Addendum: _____

If resident has filled out this form, did he or she have any assistance? _____ Yes or _____No
If yes, who assisted? _____

I have completed this Addendum to Criteria to Placement and the Entry Level Criteria for Placement to the best of my knowledge and information. I certify that the information given is true and accurate. I understand that any false or misleading information given which has an effect on the appropriateness or suitability of this placement may result in resident's discharge from the home.

_____ _____

Name of person completing form Relationship

_____

Date

_____ _____

Licensee Date

Rev.2/15 BEF