



G & G Living Centers, Inc.

Application for Services

"We empower people to maximize their independence."

Regina A. Shafer
Operations/Admissions
rshafer@gandgliving.org
Office: (563) 252-3811 ext. 45
Cell: (563) 880-1473
Fax: (563) 252-3812

Identifying Information:

Name of person seeking services: _____
Last First Middle Nickname

Social Security Number: _____ Date of Birth: _____

Current Address: _____ Phone Number: _____
Street

City State Zip County of Legal Residence: _____

Sex: _____ Marital Status: _____ Height: _____ Weight: _____

Ethnicity: ___ White non-Hispanic ___ African American non-Hispanic ___ Asian ___ Hispanic
___ American Indian ___ Other ___ Unknown

Religion (optional): _____

Name of person supplying information (if different from applicant): _____

Relationship to applicant: _____ Date form completed: _____

Date admission is desired: _____

Services Sought:

Below is a list of services provided by G & G Living Centers, Inc. Please check all the applicant may be interested in.

Residential

- ___ Community Living Home (ICF/MR)
- ___ Community Living Home (1 to 3 residents) ___ Awake night staff, or ___ Sleeping night staff
- ___ Apartment Living (site based- 24hour/day staff) ___ Awake night staff, or ___ Sleeping night staff
- ___ Supported Community Living (staff stop in at current living place for training)
- ___ Parental home ___ Own apartment
- ___ Respite (staff stays with individual in own home while family is away to provide a "break")

Vocational

- ___ Sheltered Workshop
- ___ Community Based Enclave Work Site (staff always present during work hours)
- ___ Community Based Individual Employment/ Job Coaching (staff periodically visit to check in)

- _____ Competitive Placement (just needs help finding a job)
- _____ Retirement/Adult Day Program
- _____ Vocational Evaluation (2 to 5 week evaluation of work skills and interests at various job settings)
- _____ Adjustment Services (3 to 5 week training on general job traits)
- _____ Other (please describe): _____

Family Information:

Emergency Contact Person Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Work Phone Number: _____

Applicant's Father's Name: _____
Current Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Level of Education Completed: _____
Place of Employment: _____ Phone Number: _____
Social Security Number ____ / ____ / ____ Health Concerns: _____

Applicant's Mother's Name: _____
Current Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Level of Education Completed: _____
Place of Employment: _____ Phone Number: _____
Social Security Number ____ / ____ / ____ Health Concerns: _____

Other Family Members Who Are Significant in Applicant's Life:

Name: _____ Date of Birth: _____ Sex: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Involved with applicant? Yes _____ No _____

Name: _____ Date of Birth: _____ Sex: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Involved with applicant? Yes _____ No _____

Name: _____ Date of Birth: _____ Sex: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Involved with applicant? Yes _____ No _____

Name: _____ Date of Birth: _____ Sex: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Involved with applicant? Yes _____ No _____

Applicant's Stepfather: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

Applicant's Stepmother: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

Health & Disability Related Information:

Applicant's primary diagnosis: _____

Applicant's secondary diagnosis (if any): _____

Date of applicant's most recent psychological exam: _____

Primary Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Dentist: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Hospital Preference: _____ Address: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Does the applicant current have or has he/she ever had any of the following (if so, please describe):

Seizures or convulsions: _____

Describe: _____

Physical limitations or mobility impairments: _____

Describe: _____

Sensory impairments: _____

Describe: _____

Speech or language impairments: _____

Describe: _____

Emotional or mental health problems: _____

Describe: _____

Behavioral difficulties: _____

Describe: _____

Has the applicant had any serious injuries?: _____

Describe: _____

Please describe any special equipment required: _____

Please list any hospitalizations or surgeries: _____

Describe: _____

Describe any on-going health problems: _____

List any allergies: _____

Previous Illnesses (List Date: mo/yr)

Chicken Pox: _____ Ear Infection: _____ Measles: _____

Tonsillitis: _____ Mumps: _____ Asthma: _____

Polio: _____ Hayfever: _____ Diabetes: _____

Hepatitis: _____ Tuberculosis: _____ Cardiac: _____

Previous Surgeries: _____

Immunizations: (circle if received and then list date underneath)

Measles Mumps Rubella Mantoux Flu DPT Typhoid Polio

Please list any current medications, dosage, and prescribed physician :

Medication:

Dosage:

Physician:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Educational/ Residential/ Vocational History:

Type of School	Name of School	Location	Program or Level	Year Completed
Grade School				
High School				
Post High School				

Please list below any previous jobs held, or jobs tried as part of vocational exploration/ training:

Job Title	Dates Worked	Pay Rate	Brief Description of Job Tasks	Why no longer there?
1.	/	\$		
2.	/	\$		
3.	/	\$		

Please list below any previous residential or in-home services that have been received:

Name of Agency	Location	Service(s) Received	Dates of Service(s)	Why service(s) ended?
			/ / - / /	
			/ / - / /	

Does the applicant have any of the following sources of financial support?

SSI: _____ If so, amount: _____
 Social Security Disability: _____ If so, amount: _____
 Veterans Benefits: _____ If so, amount: _____

Railroad or Other: _____ If so, amount: _____
 Other sources of Income: _____ If so, amount: _____
 Does the applicant have a legal guardian? _____ Name: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date appointed: _____ County: _____

Does the applicant have a legal conservatorship? _____ Conservator: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date appointed: _____ County: _____

Does the applicant have a representative payee? _____ Payee: _____

Please complete any of the following that apply:

Name of Medical Insurance Provider: _____

Medicaid Number: _____

Medicare Number: _____

Skills Checklist

Check items that best describe applicant:

Feeding	Consistently	Sometimes	Never	Comments
Requires physical assist to eat				
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				
Shows good table manners				
Completely independent				

Dressing	Consistently	Sometimes	Never	Comments
Requires physical assistance				
Resists dressing				
Assists in dressing				
Puts on most clothing indep.				
Buttons clothes				
Ties Shoes				

Chooses own clothing				
Completely independent				

Grooming	Consistently	Sometimes	Never	Comments
Total dependent				
Washes hands				
Washes face				
Brushes teeth				
Combs or brushes hair				
Bathes self independently				
Shaves self				
Shampoos hair				
Completely independent				

Toileting	Consistently	Sometimes	Never	Comments
Requires control briefs				
Scheduled toileting				
Can indicate need				
Wets/soils during the day				
Wets/soils during the night				
Bathes self independently				
Cares for self at toilet				
Uses toilet independently				
Cares for self during menstruation				

Social Relations	Consistently	Sometimes	Never	Comments
Needs close supervision				
Avoids interaction with peers				
Enjoys interaction with peers				
Involves self near, not with peers				
Disrupts group activities				

Communication	Consistently	Sometimes	Never	Comments
Does not respond to language				
Communicates with gestures only				
Speaks single words				
Uses phrases				
Uses sentences				
Speech easily understood				
Follows simple directions				
Answers questions				
Converses spontaneously				
Talks on telephone				
Prints/ Writes				

Human Sexuality	Consistently	Sometimes	Never	Comments
Demonstrates knowledge of own sexuality				
Demonstrates knowledge of other's sexuality				
Masturbates privately				
Masturbates publicly				
Actively displays interest in same sex				
Actively displays interest in opposite sex				

Chores and Activities	Consistently	Sometimes	Never	Comments
Helps with minor household tasks				
Does responsible routine chores				
Goes about neighborhood without supervision				
Makes purchases				
Uses public transportation buses/ taxi				

Behaviors	Check if Yes	Comments/ Explain
Hyperactive		
Aggressive		
Withdrawn		
Hits/ kicks others		
Bites others		
Pulls others hair		
Uses disruptive noises		
Self-stimulates, i.e. rocks back and forth		
Engages in self-injurious behavior		
Abusive of property		
Leaves premises without permission		
Physically abused others		
Screams		
Eats inappropriate objects/ fluids		
Engages in rectal digging		

If others, explain: _____

Does the applicant have a criminal history? _____
 If yes, please explain any criminal charges and related court conditions (i.e. probation status, no contact orders, etc.): _____

Application completed by: _____ **Date:** _____
Current Address: _____ **Phone Number:** _____
City: _____ **State:** _____ **Zip Code:** _____