Shenandoah Valley Community Residences, Inc.
301 N. Cameron St., Ste 103● Winchester,VA 22601●540/536-0336●540/536-3207 Fax
Helping people with intellectual disabilities attain independence!

APPLICATION FOR RESIDENTIAL SERVICES

DATE: _____

I. PERSONAL

APPLICANT'S NAME: _____
(last) (first) (middle)

PRESENT ADDRESS: _____
(street)

_____ PHONE: _____
(city) (state) (ZIP)

SOCIAL SECURITY #:_____ PLACE OF BIRTH:_____

DATE OF BIRTH:_____ AGE: _____ SEX:_____ RACE:_____

MARITAL STATUS:_____ HEIGHT: _____ WEIGHT: _____

COLOR OF HAIR: _____ COLOR OF EYES: _____

IDENTIFYING MARKS (birthmarks; scars; etc.) :_____

II. FAMILY

MOTHER'S NAME: _____ MAIDEN NAME: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

PLACE OF BIRTH: _____ DATE OF BIRTH: _____

IF DECEASED, DATE AND CAUSE OF DEATH:_____
_____

FATHER'S NAME: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

PLACE OF BIRTH: _____ DATE OF BIRTH: _____

IF DECEASED, DATE AND CAUSE OF DEATH:_____

_____

PARENTS' HEALTH:_____ MARITAL STATUS: _____

III. APPLICANT'S LEGAL STATUS **(copies of all documents required upon admission)**

HAS GUARDIANSHIP BEEN GRANTED DUE TO A COMPETENCY HEARING: Yes

IF YES, DATE OF HEARING: _____ COURT:_____ PLACE:_____

NAME OF GUARDIAN(S): _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

HAS AN AUTHORIZED REPRESENTATIVE BEEN APPOINTED: Yes

IF YES, BY WHOM: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

NAME OF CARE PROVIDER(S) IF DIFFERENT FROM PARENTS OR LEGAL GUARDIAN:

NAME : _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

LIST APPLICANT'S BROTHERS AND SISTERS:

NAME	AGE	NAME	AGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IV. FINANCIAL

IS APPLICANT EMPLOYED? Yes _____ COMPETITIVE; _____ SHELTERED

PLACE OF EMPLOYMENT: _____

DATE EMPLOYMENT BEGAN: _____ AVE. MONTHLY INCOME: $_____

DOES APPLICANT RECEIVE ANY OF THE FOLLOWING BENEFITS?

Social Security Disability Benefits (SSDI) $ _____/month
Supplemental Security Income (SSI) $ _____/month
Veteran's Benefits (VA) $ _____/month
Other income benefits (describe) _____
_____$ _____/month

DOES APPLICANT HAVE MEDICAID WAIVER FUNDING? Yes

IF NO, IS APPLICANT ON THE MEDICAID WAIVER WAITING LIST? Yes

HAS A REPRESENTATIVE PAYEE BEEN APPOINTED: Yes

IF YES, NAME OF PAYEE: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

DOES THE APPLICANT HAVE HEALTH INSURANCE? (please check) **(copies of all documents required upon admission)**

Virginia Medicaid _____ #: _____
Medicare _____ #: _____
Other Health Insurance _____ #: _____
Name of Company: _____
Policyholder : _____ Type of Coverage: _____

DOES APPLICANT HAVE LIFE INSURANCE? yes / no (circle) **(copies of document required upon admission)**

Name and Address of Company: _____

Policyholder : _____ Policy Number: _____ Value: _____

DOES APPLICANT HAVE PRE-PAID IRREVOCABLE BURIAL ARRANGEMENT? Yes
Name and Address of Company: _____
Policyholder : _____ Policy Number: _____
(copies of document required upon admission)

V. NATURE OF DISABILITY

PRIMARY DISABILITY: _____

AGE OF ONSET: _____ NATURE / CAUSE: _____

_____

SECONDARY DISABILITY: _____

AGE OF ONSET: _____ NATURE / CAUSE: _____

_____

OTHER DISABILITIES: _____

_____

LIST ALL MEDICAL FACILITIES, EVALUATION CENTERS, INSTITUTIONS, ETC., FROM WHICH THE APPLICANT HAS RECEIVED SERVICES (most recent first). DESCRIBE WHAT INTERVENTIONS, TESTS, OR EVALUATIONS WERE PERFORMED (e.g.: medical, psychological, vocational). NOTE DATES AND RESULTS, USING BACK OF PAGE IF NEEDED.

_____

_____

_____

_____

_____

_____

_____

_____

******Attach a copy of the most recent Psychological Evaluation******

VI. SOCIAL / DEVELOPMENTAL HISTORY

HOW DOES THE APPLICANT SPEND HIS/HER LEISURE TIME? (daily routine, hobbies, sports activities, religious or community activities, clubs or organizational membership, etc.)

_____

_____

_____

DESCRIBE HOW THE APPLICANT RELATES TO OTHERS (i.e., brothers and sisters, parents, peers, strangers, care givers, etc.): DOES THE APPLICANT ENJOY BEING AROUND OTHERS? DOES THE APPLICANT SPEND A LOT OF TIME ALONE?

_____

_____

_____

DOES THIS PERSON TEASE OTHERS? START ARGUMENTS? ACCEPT CRITICISM? DESCRIBE ANY BEHAVIORAL OR ACTING-OUT PROBLEMS REQUIRING SPECIAL GUIDANCE:

_____

_____

_____

HAS THE APPLICANT BEEN KNOWN TO RUN AWAY FROM HOME? Yes IF YES, HOW FREQUENTLY? _____

HAS APPLICANT EVER BEEN ARRESTED? Yes IF YES, PLEASE EXPLAIN:

_____

_____

HAS THE APPLICANT BEEN KNOWN TO PLAY WITH MATCHES? Yes IF YES, HOW FREQUENTLY? _____

HAS APPLICANT EVER RECEIVED SEX EDUCATION? Yes IF YES, WHEN AND WHERE:

_____

HAS THE APPLICANT BEEN KNOWN TO DISPLAY INAPPROPRIATE SEXUAL TENDENCIES TOWARD OTHERS? Yes IF YES, DESCRIBE:_____

_____

HAS THE APPLICANT BEEN KNOWN TO OPENLY MASTURBATE? Yes

DOES APPLICANT REGULARLY USE ANY OF THE FOLLOWING?

TOBACCO _____ ALCOHOL _____

DOES THE APPLICANT HAVE A HISTORY OF SUBSTANCE ABUSE? yes / no (circle)
HAS THE APPLICANT BEEN KNOWN TO USE ILLEGAL DRUGS? yes / no (circle)
IF YES, PLEASE DESCRIBE THE ONSET OF USE, TYPES OF SUBSTANCES, FREQUENCY OF USE, QUANTITY OF USE, AND METHOD OF USE:

_____

_____

VII. PHYSICAL / HEALTH

LIST APPLICANT'S PHYSICIANS, LENGTH OF TIME IN THEIR CARE, AND SPECIALTY OF SERVICE (e.g., General Practitioner, Neurologist, Internist, Psychiatrist, Dentist):

NAME: _____ PHONE #: _____

ADDRESS: _____

LENGTH OF TIME: _____ SPECIALITY: _____

NAME: _____ PHONE #: _____

ADDRESS: _____

LENGTH OF TIME: _____ SPECIALITY: _____

NAME: _____ PHONE #: _____

ADDRESS: _____

LENGTH OF TIME: _____ SPECIALITY: _____

DATE OF LAST PHYSICAL EXAM: _____ DENTAL EXAM: _____

DATE OF LAST TUBERCULOSIS TEST: _____ TYPE: _____ RESULT: _____

DOES APPLICANT HAVE ANY CHRONIC ILLNESSES? Yes IF YES, PLEASE EXPLAIN:

_____

DESCRIBE ANY SHORT-TERM CONDITIONS PRESENTLY BEING TREATED:_____

_____

IS APPLICANT AMBULATORY? Yes DOES APPLICANT HAVE FULL USE OF BOTH ARMS AND HANDS? DESCRIBE ANY PHYSICAL LIMITATIONS:

_____

_____

DOES THE APPLICANT KNOW HOW TO SWIM? Yes

DOES APPLICANT WEAR GLASSES? Yes DATE OF LAST EXAM: _____

DOES APPLICANT WEAR A HEARING AID? Yes DATE OF LAST EXAM: _____

DOES APPLICANT USE ANY OTHER PROSTHETIC DEVICES? Yes IF YES, PLEASE DESCRIBE:

_____ _____

DOES APPLICANT HAVE ANY ALLERGIES: Yes IF YES, PLEASE DESCRIBE:

_____

DOES APPLICANT HAVE A SPECIAL DIET? : Yes IF YES, PLEASE DESCRIBE:

_____

DOES APPLICANT HAVE AN EATING DISORDER? ____ overeats ____under eats
____eats inedible items (describe): _____

DOES APPLICANT HAVE A HISTORY OF SEIZURES? Yes IF YES, TYPE:_____

AGE OF ONSET: _____ FREQUENCY: _____

ARE SEIZURES CONTROLLED BY MEDICATION? Yes IF YES:

NAME OF MEDICATION	DOSAGE	# TIMES PER DAY
_____	_____	_____
_____	_____	_____

LIST OTHER MEDICATIONS APPLICANT CURENTLY TAKES:

_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DOES APPLICANT NEED ASSISTANCE ADMINISTERING MEDICATION: Yes

IF YES, PLEASE DESCRIBE: _____

LIST ANY OTHER MEDICAL PRECAUTIONS OR SPECIAL HEALTH NEEDS:

_____

_____

_____

LIST SERIOUS ILLNESS AND CHRONIC CONDITIONS OF APPLICANT'S PARENTS AND SIBLINGS (if known): _____

_____

_____

VIII. EDUCATION / TRAINING

LIST CURRENT AND PREVIOUS INSTITUTIONS, SCHOOLS, COMMUNITY RESIDENTIAL AND VOCATIONAL TRAINING PROGRAMS APPLICANT HAS ATTENDED (most recent first):

NAME & LOCATION	TYPE OF PROGRAM	DATES
_____	_____	from _____ to _____
_____	_____	from _____ to _____
_____	_____	from _____ to _____
_____	_____	from _____ to _____

WORK HISTORY

TYPE OF WORK: _____

DATES OF EMPLOYMENT: _____

REASON FOR LEAVING:_____

DOES APPLICANT HAVE ANY EMPLOYMENT INTERESTS? Yes IN WHAT AREAS?

_____

IX. REFERRAL INFORMATION

NAME OF PERSON MAKING REFERRAL: _____

RELATIONSHIP TO APPLICANT: _____

DOES APPLICANT HAVE A CASE MANAGER OR SOCIAL WORKER? Yes

IF YES, NAME: _____ AGENCY: _____

ADDRESS: _____ PHONE: _____

LIST OTHER AGENCIES OR PERSONNEL PROVIDING SUPPORT SERVICES TO APPLICANT:

AGENCY / CONTACT PERSON	TYPE OF SERVICE	PHONE#
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DESCRIBE REASONS FOR REQUESTING RESIDENTIAL SERVICES, INCLUDING APPLICANT'S PRESENT LIVING SITUATION:

_____

_____

_____

IN ORDER OF IMPORTANCE, LIST THE APPLICANT'S TRAINING NEEDS WITHIN A RESIDENTIAL PROGRAM:

1. _____

2. _____

3._____

HOW MUCH SUPERVISON DOES APPLICANT REQUIRE? (i.e., total? 20 hours/week?, etc.)

_____

HOW LONG WILL RESIDENTIAL SERVICES BE NEEDED? _____

IF APPLICANT IS NOT ADMITTED TO RESIDENTIAL SERVICES AT THIS TIME, WHAT IS YOUR ALTERNATE PLAN? _____

ADDITIONAL COMMENTS THAT SHOULD BE CONSIDERED FOR POSSIBLE ADMISSION (i.e., health of care providers, level of stress in home environment, risk of institutionalization):

_____

_____

_____ _____

Signature of Person Completing Application Date

IMMUNIZATION RECORD

Name: _____

Vaccine	Date	Vaccine	Date	Vaccine	Date
DPT		OPV		MEASLES	
DPT		OPV		RUBELLA	
DPT		OPV		MUMPS	
DPT		OPV		HB VACCINE	

Tetanus Vaccination (TD)

Date

Tuberculosis Screenings

Date	Type	Strength	Reaction

Influenza

Date	Strain

Chest X-ray Results

Date	Results

SKILL LEVEL EVALUATION

PART I

1 – NEEDS CONSTANT SUPERVISION
2 – NEEDS SUPERVISION WITH PROMPTING
3 – NEEDS SUPERVISION SOMETIMES WITH A PROMPT
4 – HANDLES TASK REASONABLY INDEPENDENTLY

DAILY LIVING SKILLS	LEVEL			
CAN SHOP FOR PERSONAL ITEMS	1☐	2☐	3☐	4☐
CAN SHOP FOR GROCERIES	1☐	2☐	3☐	4☐
CAN PREPARE SIMPLE MEALS AND PACK OWN LUNCH	1☐	2☐	3☐	4☐
CAN COOK SIMPLE RECIPES USING DIRECTIONS ON THE BOX	1☐	2☐	3☐	4☐
CAN PROPERLY STORE FOOD	1☐	2☐	3☐	4☐
CAN WASH DISHES BY HAND	1☐	2☐	3☐	4☐
CAN OPERATE THE DISHWASHER	1☐	2☐	3☐	4☐
CAN VACUUM, DUST, SWEEP, MOP FLOORS	1☐	2☐	3☐	4☐
CAN TELL TIME	1☐	2☐	3☐	4☐
CAN USE ALARM CLOCK TO AWAKEN	1☐	2☐	3☐	4☐
CAN DRESS INDEPENDENTLY, AND GO TO WORK	1☐	2☐	3☐	4☐
CAN PROPERLY STORE CLOTHING	1☐	2☐	3☐	4☐
CAN COUNT FROM 1-10	1☐	2☐	3☐	4☐
CAN USE TELEPHONE	1☐	2☐	3☐	4☐
MONEY HANDLING				
CAN COUNT CHANGE TO MAKE $.50 OR $1.00 IN NICKELS, DIMES QUARTERS, AND PENNIES	1☐	2☐	3☐	4☐
CAN MAKE CHANGE FOR $5.00	1☐	2☐	3☐	4☐
CAN RECEIVE CHANGE FROM PURCHASES	1☐	2☐	3☐	4☐
CAN ADD SIMPLE SUMS (TAXI FARES, LUNCH MONEY)	1☐	2☐	3☐	4☐
PERSONAL HYGIENE				
CAN BATHE	1☐	2☐	3☐	4☐
CAN WASH HAIR	1☐	2☐	3☐	4☐
CAN BRUSH TEETH	1☐	2☐	3☐	4☐
CAN CARE FOR OWN MENSTRUAL CYCLE	1☐	2☐	3☐	4☐
CAN USE PERSONAL HYGIENE PRODUCTS	1☐	2☐	3☐	4☐
CAN WASH OWN CLOTHES	1☐	2☐	3☐	4☐
CAN DRESS APPROPRIATELY (WEATHER, FUNCTION)	1☐	2☐	3☐	4☐
CAN CHANGE SHEETS AND MAKE OWN BED	1☐	2☐	3☐	4☐
CAN SHAVE (face, legs, underarms)	1☐	2☐	3☐	4☐
COMMUNICATION – SOCIALIZATION				
CAN MAKE INQUIRES FROM A POLICEMAN IN AN EMERGENCY	1☐	2☐	3☐	4☐
CAN CALL A CAB AND GIVE ADDRESS AND DESTINATION	1☐	2☐	3☐	4☐
CAN USE LOCAL STORES, RESTAURANTS, BANKS	1☐	2☐	3☐	4☐
CAN DISPLAY APPROPRIATE BEHAVIOR IN THE COMMUNITY	1☐	2☐	3☐	4☐

CAN REMEMBER, RECITE AND IDENTIFY OWN PHONE NUMBER	1☐	2☐	3☐	4☐
CAN ORDER SIMPLE MEALS IN A RESTAURANT	1☐	2☐	3☐	4☐
APPLIANCE USAGE				
CAN USE A STOVE AND OVEN SAFELY	1☐	2☐	3☐	4☐
CAN USE A MICROWAVE OVEN SAFELY	1☐	2☐	3☐	4☐
CAN USE THE GARBAGE DISPOSAL	1☐	2☐	3☐	4☐
CAN USE CLOTHES WASHER AND DRYER	1☐	2☐	3☐	4☐
CAN USE VACUUM CLEANER	1☐	2☐	3☐	4☐
CAN USE A CAN OPENER	1☐	2☐	3☐	4☐
CAN USE UTENSILS TO EAT, COOK, SLICE, ETC.	1☐	2☐	3☐	4☐
EMERGENCY SITUATION				
CAN ASK FOR ASSISTANCE IN AN EMERGENCY SITUATION	1☐	2☐	3☐	4☐
CAN USE A FIRST AIDE KIT AND CARE FOR MINOR CUTS, BURNS, ABRAISONS	1☐	2☐	3☐	4☐
CAN DIAL 911 AND IDENTIFY SELF, EXPLAIN THE EMERGENCY, GIVE THE LOCATION AND PHONE NUMBER	1☐	2☐	3☐	4☐
BANKING				
CAN WRITE A CHECK AND SIGN IT	1☐	2☐	3☐	4☐
CAN CASH A CHECK	1☐	2☐	3☐	4☐
CAN MAKE A DEPOSIT	1☐	2☐	3☐	4☐
CAN WRITE A DEPOSIT SLIP	1☐	2☐	3☐	4☐
CAN BALANCE A CHECKBOOK	1☐	2☐	3☐	4☐

PART II QUESTIONNAIRE

This questionnaire is not intended in any way to judge behaviors. It is used as a baseline for staff to better understand the individual.

1. Has the applicant ever stolen items at: ____ home _____ work _____store
2. Has the applicant been known to destroy: ____ own personal property ____ household items ____ the property of others
3. Is the applicant able to accept the consequences of his/her own behavior? _____
4. Does the applicant know the difference between right and wrong? _____
5. Does the applicant have respect for persons in positions of authority? _____
6. Does the applicant understand his rights as a human being and a citizen? _____
7. Is the applicant sexually active? _____ If yes, does the applicant understand safe sex? _____
8. Does the applicant have a religious preference? What? _____
   Is it important that church activities be attended regularly? _____