RESIDENTIAL APPLICATION

Please complete application and return to:
Tiffany Collins
731 Sims Avenue
Columbia, SC 29205
www.umcsc.org/home/ministries/outreach/aldersgate-special-needs-ministry/

RESIDENT INFORMATION

FULL NAME	PREFERRED NAME	DATE OF APPLICATION
PRESENT ADDRESS		
CITY/STATE/ZIP	PHONE ( )	
DATE OF BIRTH	PLACE OF BIRTH	SEX ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER	FOR WHICH REGION ARE YOU APPLYING? ☐ NO PREFERENCE ☐ COLUMBIA ☐ ORANGEBURG ☐ ROCK HILL ☐ FLORENCE ☐ OTHER	
PARENTS NAMES		
ADDRESS (IF DIFFERENT FROM ABOVE)	E-MAIL:	
CITY/STATE/ZIP	PHONE	
LEGAL GUARDIANSHIP STATUS		
NAME OF LEGAL GUARDIAN		
ADDRESS		
CITY/STATE/ZIP	PHONE	
LIST NAMES/ADDRESSES/PHONE NUMBERS FOR OTHER MEMBERS OF IMMEDIATE FAMILY		
PERSON TO BE NOTIFIED IN CASE OF EMERGENCY		
CITY/STATE/ZIP	PHONE	
RELIGIOUS AFFILIATION		

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APPLICANT NAME

REASON FOR REQUESTING ADMISSION

WHAT SERVICES IS THE APPLICANT RECEIVING, OR ARE THERE ANY PENDING SERVICES?

IDENTIFY DISABILITY: (CHECK ALL THAT APPLY)

MR LEVEL: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND

☐ DEAFNESS ☐ ORTHOPEDIC IMPAIRMENT ☐ DEVELOPMENTAL DELAY

☐ CEREBRAL PALSY ☐ HEARING IMPAIRED ☐ SPEECH IMPAIRMENT

☐ AUTISM ☐ BLINDNESS ☐ SEIZURE

☐ EMOTIONAL ☐ VISUAL IMPAIRMENT

☐ AT RISK ☐ LEARNING DISABILITY

OTHER DIAGNOSIS:

APPLICANT'S FINANCIAL INFORMATION

INCOME (SSI, SOCIAL SECURITY, EMPLOYMENT, ETC.):

SOURCE	MONTHLY AMOUNT
1.	$
2.	$
3.	$
4.	$

IS APPLICANT HIS OWN PAYEE? ☐ YES ☐ NO	IF NOT, WHO IS?	

PROPERTY:

DESCRIPTION/LOCATION	VALUE
1. REAL ESTATE	
2. OTHER	

SAVINGS ACCOUNTS, STOCKS, CHECKING ACCOUNT:

TYPE	AMOUNT
1.	
2.	
3.	
4.	

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INSURANCE INFORMATION:

PRIVATE INSURANCE: ☐ YES ☐ NO		NUMBER OF POLICIES:
WHERE?		
POLICY/GROUP HOLDER NAME		SUBSCRIBER ID/GROUP #
COMPANY(S) NAME AND ADDRESS		
IS APPLICANT A MEDICAID RECIPIENT, OR ELIGIBLE RECIPIENT? ☐ YES ☐ NO IF YES, DO YOU HAVE PRIVATE INSURANCE? ☐ YES ☐ NO	MEDICAID NUMBER	MEDICARE NUMBER
OTHER INSURANCE		

DOES THE APPLICANT CURRENTLY RECEIVE A SERVICE/FUNDING SOURCE (ID/RD, COMMUNITY SUPPORTS WAIVER, ETC)? ☐ YES ☐ NO

IF YES WHICH ONES:

IS APPLICANT ON WAITING LIST FOR A DDSN WAIVER ☐ YES ☐ NO IF YES PLEASE LIST THEM :

SOCIAL HISTORY INFORMATION: TO BE COMPLETED BY FAMILY AND APPLICANT OR CASEWORKER)

EDUCATION (WHEN AND WHERE):
SPECIAL EDUCATION OR TRAINING:
TYPE OF WORK EXPERIENCE (IF ANY):
HISTORY OF RESIDENCE (CITY, COUNTY, STATE) AND APPROXIMATE DATES:
WHAT TYPES OF FAMILY AND COMMUNITY SUPPORTS ARE IN PLACE FOR THE INDIVIDUAL?
WHAT ARE THE FAMILY'S PLANS FOR FUTURE INVOLVEMENT?
WHAT ARE THE FAMILY'S PLANS IF TRIAL PLACEMENT IS UNSATISFACTORY?
HOW DOES APPLICANT FEEL ABOUT LIVING IN A GROUP HOME?

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MENTAL CAPABILITIES

HAS APPLICANT EVER BEEN TREATED BY A PSYCHIATRIST/PSYCHOLOGIST, STATE HOSPITAL, MENTAL HEALTH CENTER? (ANSWER AND EXPLAIN WITH DATES.)
DESCRIBE ANY UNUSUAL OR PECULIAR BEHAVIOR HABITS THAT THE HOME SHOULD KNOW ABOUT, SUCH AS SEXUAL, BEHAVIORAL, AND PSYCHOLOGICAL CONCERNS PLEASE BE HONEST AND AS DETAILED AS POSSIBLE:
DESCRIBE THE APPLICANT'S ABILITY TO GET ALONG WITH OTHERS:
DESCRIBE THE APPLICANT'S ABILITY TO REMEMBER, UNDERSTAND SPEECH, AND ABILITY TO THINK AND RESPOND:
IS APPLICANT AWARE OF TIME AND PLACE?
DOES APPLICANT SIGN HIS/HER OWN NAME ON LEGAL FORMS AND CHECKS? ☐ YES ☐ NO

PHYSICAL CAPABILITIES

DESCRIBE ANY PHYSICAL IMPAIRMENT (VISION, SPEECH, HEARING, ETC.):
DESCRIBE APPLICANT'S ABILITY TO WALK, STAND, BEND, SIT UP, USE ARMS, LEGS, AND HANDS:
CAN APPLICANT: ▪ FEED HIM/HERSELF ☐ YES ☐ NO EXPLAIN:
▪ BATHE HIM/HERSELF ☐ YES ☐ NO EXPLAIN:
▪ DRESS HIM/HERSELF ☐ YES ☐ NO EXPLAIN:

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LIST HOSPITALIZATIONS WITHIN THE LAST FIVE YEARS, INCLUDING REASONS, DATES, PLACE:

SUMMARY OF IMMUNIZATIONS, HEP B SERIES/SCREENING, DRUG SENSITIVITIES, CURRENT MEDICAL REQUIREMENTS, AND ANY SPECIAL MEDICAL PROBLEMS:

WHAT TYPE OF INTERESTS DOES THE APPLICANT HAVE?

LIST THE APPLICANT'S STRENGTHS:

DESCRIBE THE APPLICANT'S CHALLENGES:

HAVE FUNERAL ARRANGEMENTS BEEN MADE ☐ YES ☐ NO
IF YES, PLEASE LIST THEM:

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CERTIFICATION

ASNM PROHIBITS USE OF ILLEGAL DRUG USE OR OTHER CRIMINAL ACTIVITIES. DO YOU ENGAGE IN ILLEGAL DRUG USE OR OTHER CRIMINAL ACTIVITY?

[ ] YES [ ] NO

I CERTIFY THAT ALL PERTINENT INFORMATION REGARDING BEHAVIORAL PROBLEMS, SEXUAL PROBLEMS, PSYCHOLOGICAL PROBLEMS, DRUG USE OR OTHER CRIMINAL ACTIVITY, AND ANY INCIDENTS THAT HAVE OCCURRED IN THESE AREAS HAVE BEEN GIVEN TO THE ADMISSIONS COMMITTEE. NO INFORMATION HAS BEEN WITHHELD. I HEREBY GIVE MY CONSENT FOR RELEASE OF ALL MEDICAL INFORMATION AND SOCIAL, VOCATIONAL, AND PSYCHOLOGICAL EVALUATIONS AS NEEDED TO THE ASNM ADMISSIONS COMMITTEE FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR PLACEMENT IN THE ASNM RESIDENTIAL PROGRAM.

APPLICANT SIGNATURE OR MARK | DATE

WITNESS (PARENT OR GUARDIAN) | DATE

APPLICANT STATEMENT

I HEREBY APPLY FOR ADMISSION TO THE ASNM RESIDENTIAL PROGRAM. I AGREE TO ABIDE BY THE RULES AND REGULATIONS OF THE HOME AND UNDERSTAND THAT VIOLATION OF THE RULES CAN RESULT IN DISCHARGE.

APPLICANT SIGNATURE OR MARK | DATE

WITNESS (PARENT OR GUARDIAN) | DATE

PERSON COMPLETING APPLICATION

NOTE TO APPLICANT

THIS APPLICATION MUST BE ACCOMPANIED BY:

- RECENT PSYCHOLOGICAL REPORT (WITHIN 12 MONTHS)
- APPLICANT PHOTOGRAPH
- MEDICAL HISTORY

IF ACCEPTED FOR ADMISSION:

- MEDICAL EXAM WILL BE REQUIRED
- HEP B SERIES/SCREENING
- TWO STEP TB TEST
- FUNERAL ARRANGEMENTS COMPLETE
- LEGAL GUARDIANSHIP PAPERWORK COMPLETED WILL BE REQUIRED