L'Arche Jacksonville Core Member Admission Application

Date of Application _____ Admission Date _____
Home _____

GENERAL INFORMATION

Applicant's Full Name _____ _____ _____
Last First Middle
Social Security Number _____ Date of Birth _____ Sex ____

Marital Status _____ Race _____ Eye Color _____ Hair Color _____

Height _____ Weight _____ Any Identifying Marks _____

United States Citizen Yes ___ No ___ If "no" please identify citizenship _____

Language Spoken or Understood _____ Religious Preference _____

Current Address _____ _____
Street, P.O. Box or RR City

_____ _____ _____
County State Zip Code
(_____)_____ (____)_____
Home Phone Number Alternate Phone Number

Email Address_____

Diagnosis _____
Age at onset of diagnosis (birth or later)_____

Alternate Placements Considered (Name of Agency, Address, Telephone)

1. _____

Reason for Referral _____

Admission: Voluntary or Involuntary _____ Legal Competency _____

Name of Court-Appointed Guardian/Conservator _____

Date of Court Appointment _____
(If a guardianship or conservatorship has been established, attach a copy of the court order)

Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Alternative Telephone (_____)_____

FAMILY INFORMATION

Father's Name _____ _____ _____ SS # _____
Last First Middle
Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
DOB _____ City and State of Birth _____ Veteran Yes ___ No ____

Occupation _____ Health Problems _____

Date of Death (If Applicable) _____ Cause of Death_____

Mother's Name _____ _____ _____ _____ SS#_____
Last First Middle Maiden
Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
DOB _____ City and State of Birth _____ Veteran Yes ___ No ____

Occupation _____ Health Problems _____

Date of Death (If Applicable) _____ Cause of Death_____

Date of Marriage _____ City and State _____ Date of Divorce (If Applicable)

Siblings:

Name _____ Date of Birth _____ Relationship to Applicant_____
Occupation _____ Address _____

Name _____ Date of Birth _____ Relationship to Applicant_____
Occupation _____ Address _____

Name _____ Date of Birth _____ Relationship to Applicant_____
Occupation _____ Address _____

Please list family member currently living at home (if applicable)
_____ _____ _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship _____
Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Alternative Telephone (____)_____

Name _____ Relationship _____
Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Alternative Telephone (____)_____

MEDICAL INFORMATION

Current Primary Care Physician _____ Date of Last Exam _____

Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Fax Number (____)_____

Current Specialist _____ Specialty _____ Date of Last Exam _____

Reason _____

Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Fax Number (____)_____

Current Specialist _____ Specialty _____ Date of Last Exam _____

Reason _____

Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Fax Number (____)_____

Current Pharmacist _____

Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Fax Number (____)_____

Current Dentist _____ Date of Last Exam _____

Address _____ _____ _____ _____
Street, Box or RR City State Zip Code

Telephone (____)_____ Fax Number (____)_____

Current Optometrist/Ophthalmologist _____
Date of Last Exam _____

Address _____ _____ _____ _____
Street, Box or RR City State Zip Code
Telephone (____)_____ Fax Number (____)_____

Other Pertinent Information About Doctors

_____
_____
_____
_____

CURRENT MEDICATIONS

Name	Dose	Frequency	Reason for Taking	Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How does the applicant take medication?

Swallows ____ Chews ____ Crushed in Food ____ Liquid Meds _____ Other _____

ALLERGIES

Is applicant allergic to medications? Yes ____ No ____
Is applicant allergic to foods? Yes ____ No ____
Is applicant allergic to anything else? Yes ____ No ____

Please list specific allergies	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

____

DIET

Is applicant on a special diet as ordered by a doctor? Yes ____ No____

Physician _____

Date Started _____ Type of Diet _____

Reason for Diet _____

_____

SPECIAL DEVICES

Does applicant require any of the following?

Device _____ Yes ____ No ____ Date Began _____

Wheelchair _____ Yes ____ No ____ Date Began _____
Walker _____ Yes ____ No ____ Date Began _____
Dentures _____ Yes ____ No ____ Date Began _____
Hearing Aid _____ Yes ____ No ____ Date Began _____
Glasses _____ Yes ____ No ____ Date Began _____
Other _____ Yes ____ No ____ Date Began _____

HOSPITALIZATIONS (Due to operations, injuries, Illness)

Date_____ Nature of Hospitalization_____ Name and Address of Hospita____

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

ILLNESS AND DISEASES (Provide Year)

Chicken Pox _____ German Measles _____ Pneumonia _____

Mumps _____ Whooping Cough _____ Tuberculosis _____

Scarlet Fever _____ Rheumatic Fever _____ Hepatitis A _____

Cardiac Probs _____ Diabetes _____ Hepatitis B _____

Cancer _____ Other and Comments _____

Was there anything abnormal about the applicant's birth? _____

Is applicant prone to any of the following? (check if yes)

Asthma ____ Strep Throat ___ Colds ___ Constipation ___ Nose Bleeds ___ Diarrhea ___

Vaginal Infections ___ Urinary Tract Infections ___ Weight Gain ___ Other (Explain)

Does applicant have seizures? Yes ___ No ___ Age at onset? _____

Date of last seizure _____ Type of seizure _____

Frequency of Seizures: Number per month _____ Per Year _____

Type of seizures _____
_____

Does applicant have any hearing problems? Yes ____ No ____

Does applicant have any vision problems? Yes ____ No ____

IMMUNIZATIONS

Type of Vaccine	Date	Booster
DPT/TD Series	_____	_____
Polio Series	_____	_____
Measles (Rubeola)	_____	_____
German Measles (Rubella)	_____	_____
Mumps	_____	_____
Other _____	_____	_____

Has applicant ever had a positive Tine? Yes ___ No ___

Date of last chest x-ray _____

Date of last:

TB Skin Test _____ Results _____

Tetanus Shot _____
Flu Vaccine _____
Pneumonia Vaccine _____

Has applicant been sterilized? Yes ___ No ___ Method _____ Date _____

PLACEMENT HISTORY

List hospitalizations, residential placements, diagnostic evaluations, vocational programs, etc. List chronological order beginning with the most recent. Use an additional page if needed.

Name of Facility _____

Address _____ _____ _____ _____
Street, P.O. Box, RR City State Zip Code
Admission Date _____ Discharge Date _____

Reason for Admission _____

Reason for Discharge _____

Name of Facility _____

Address _____ _____ _____ _____
Street, P.O. Box, RR City State Zip Code
Admission Date _____ Discharge Date _____

Reason for Admission _____

Reason for Discharge _____

EDUCATIONAL BACKGROUND Last Grade Completed _____ Date _____

SOCIAL/RELIGIOUS INFORMATION

Are visits to the family home possible? Yes ____ No ____ How often _____

Church preference _____

Address _____ _____ _____ _____
Street, P.O. Box, RR City State Zip Code

Name of Clergy _____ Telephone (____)_____

Date of Baptism _____ Where _____

If not baptized, would you like him or her to be? Yes ____ No ____

Is the applicant eligible to receive communion? Yes ____ No ____

Has the applicant attended church in the past? Yes ____ No ____

Does the applicant attend services at (please circle one)

Protestant Catholic Other _____ No Preference

Funeral Home Name _____

Address _____ _____ _____ _____
Street, P.O. Box, RR City State Zip Code

Cemetery Name_____

Address _____ _____ _____ _____
Street, P.O. Box, RR City State Zip Code

Funds set aside in Trust Account – How much money? _____

Bank Name _____ Telephone Number (____)_____

Address _____ _____ _____ _____
Street, P.O. Box, RR City State Zip Code

Insurance Funds Available? Yes _____ Amount _____

APPLICANT'S FINANCIAL INFORMATION

(Please note complete account and eligibility numbers.)

Social Security Number _____ Medicare Number _____

MediCare Part A ___ Part B ___

Medicaid Eligibility Number _____ (Social Services, Public Welfare, Public Aid)

Is applicant Eligible for Florida MedWaiver? Yes ___ No ___ Date of Eligibility _____

Veteran's Administration Number _____

Other Health Insuraces

Company Name	Address	Policy Number

Applicant's Bank Accounts

Checking Account Balance _____
Bank Name _____ Account Number _____
Names on Account _____

Savings Account Balance _____
Bank Name _____ Account Number _____
Names on Account _____

Does applicant have resources such as property, securities, stocks, bonds, or trust accounts?
Yes ____ No _____ If "yes" please furnish detailed information as to value, co-owners, etc.
_____
_____

Applicant's Income

Type of Income	Amount Per Month	Starting Date
Wages – Employer		
Social Security		
Supplemental Social Security (SSI)		
Assistance Grants (welfare, public aid)		
Veteran's Administration		
Other (Interest, income, gifts)		
Total Monthly Income		

Family Financial Involvement

Does family plan to supplement personal spending money? Yes ___ No ___

Who is the payee for Social Security and/or SSI check? _____

Do you wish to have L'Arche Jacksonville apply to be representative payee?

Yes ___ No ___

For clothing purchases: _____ Notify me to make all purchases

_____ Notify me to send money

_____ Allow L'Arche Jacksonville to make needed purchases

For discarded clothing _____ Notify me to sort, organize, and discard

_____ Allow L'Arche Jacksonville to use their discretion to make decisions about disposing of items that no longer fit, are worn, or are no longer appropriate for wear.

APPLICATION COMPLETED BY:

_____
Full Name

_____
Relationship to Applicant

_____
Date

Please return completed application to:

L'Arche Jacksonville, Inc.
700 Arlington Road North
Jacksonville, Florida 32211

Telephone: (904) 721-5992 Fax: (904) 721-7143