



# RESIDENTIAL APPLICATION

Return to:  
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[umcsc.org/home/ministries/outreach/aldersgate-special-needs-ministry](http://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	GENDER MALE      FEMALE	
SOCIAL SECURITY NUMBER	FOR WHICH REGION ARE YOU APPLYING?      NO PREFERENCE COLUMBIA      ORANGEBURG      ROCK HILL FLORENCE <input type="checkbox"/> OTHER		
PARENTS NAMES			
ADDRESS (IF DIFFERENT FROM ABOVE)		EMAIL:	
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	

**RESIDENTIAL APPLICATION**

APPLICANT NAME
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RELIGIOUS AFFILIATION			
REASON FOR REQUESTING ADMISSION			
WHAT SERVICES IS THE APPLICANT RECEIVING, OR ARE THERE ANY PENDING SERVICES?			
IDENTIFY DISABILITY: (CHECK ALL THAT APPLY)	SEVERE	PROFOUND	DEVELOPMENTAL DELAY
MR LEVEL: MILD      MODERATE	ORTHOPEDIC IMPAIRMENT		SPEECH IMPAIRMENT
DEAFNESS	HEARING IMPAIRED		SEIZURE
CEREBRAL PALSY	BLINDNESS		
AUTISM	VISUAL IMPAIRMENT		
EMOTIONAL	LEARNING DISABILITY		
AT RISK			
OTHER DIAGNOSIS:			

**APPLICANT'S FINANCIAL INFORMATION**

<b>INCOME (SSI, SOCIAL SECURITY, EMPLOYMENT, ETC.):</b>		
<b>SOURCE</b>		<b>MONTHLY AMOUNT</b>
1.		\$
2.		\$
3.		\$
4.		\$
IS APPLICANT HIS OWN PAYEE? YES      NO	IF NOT, WHO IS?	
<b>PROPERTY:</b>		
<b>DESCRIPTION/LOCATION</b>		<b>VALUE</b>
1. REAL ESTATE		
2. OTHER		
<b>SAVINGS ACCOUNTS, STOCKS, CHECKING ACCOUNT:</b>		
<b>TYPE</b>		<b>AMOUNT</b>
1.		

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2.	
3.	
4.	

**INSURANCE INFORMATION:**

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

OTHER INSURANCE
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<b>DOES THE APPLICANT CURRENTLY RECEIVE A SERVICE/FUNDING SOURCE (ID/RD, COMMUNITY SUPPORTS WAIVER, ETC)?</b> YES NO
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IF YES WHICH ONES: IS APPLICANT ON WAITING LIST FOR A DDSN WAIVER <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES PLEASE LIST THEM : Are you seeking residency on a private pay basis? YES NO
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**SOCIAL HISTORY INFORMATION:** TO BE COMPLETED BY FAMILY AND APPLICANT OR CASEWORKER)

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

HOW DOES APPLICANT FEEL ABOUT LIVING IN A GROUP HOME?

**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.):

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DESCRIBE APPLICANT'S ABILITY TO WALK, STAND, BEND, SIT UP, USE ARMS, LEGS, AND HANDS:

CAN APPLICANT:

▪ FEED HIM/HERSELF	YES	NO	EXPLAIN:
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▪ BATHE HIM/HERSELF	YES	NO	EXPLAIN:
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▪ 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?

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LIST THE APPLICANT'S STRENGTHS:

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DESCRIBE THE APPLICANT'S CHALLENGES:

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HAVE FUNERAL ARRANGEMENTS BEEN MADE  YES  NO

IF YES, PLEASE LIST THEM:

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**CERTIFICATION**

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

YES  NO

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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
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WITNESS (PARENT OR GUARDIAN)	DATE
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**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
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WITNESS (PARENT OR GUARDIAN)	DATE
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PERSON COMPLETING APPLICATION
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**NOTE TO APPLICANT**

THIS APPLICATION MUST BE ACCOMPANIED BY:

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

**RESIDENTIAL APPLICATION**

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

APPLICANT NAME
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