Intake Application

Date of application: ___________________

Instructions: It is important that you complete this form in its entirety. If information is unknown or does not apply to the individual, please fill in the applicable fields with **unknown** or **N/A**. Do not leave any blank fields. If you have any questions, please contact Shelli Schultz at 763-331-8253.

Please fax completed form to: 763-331-9951

PERSONAL INFORMATION (*applicant should fill out this area, may use assistance)*

First Name:		Last Name:	Middle Initial:
Current Residence:			
Address:			
City:		State:	Zip:
Date of Birth:	Age:	☐ Male ☐ Female ☐ Other	Primary Language Spoken:
Daytime Contact Phone Number:		Evening Contact Phone Number:	
Emergency Contact Name:		Address:	
Daytime Phone Number:		Evening Phone Number:	

Do you have a driver's license? ☐ Yes ☐ No
Do you own a vehicle? ☐ Yes ☐ No
Do you have any pets? ☐ Yes ☐ No *If yes, is this pet a certified/registered therapy pet?* ☐ Yes ☐ No
Do you have a Guardian? ☐ Yes ☐ No Conservator? ☐ Yes ☐ No Power of Attorney ☐ Yes ☐ No
Guardian/Conservator/Power of Attorney: Name: ________________ Phone #: ________________
CADI/BI Waiver Case Manager: Name: ________________ Phone #: ________________
Person to receive status of application: Name: ________________ Phone #: ________________
There is No-Smoking allowed in the buildings. Are you okay with NOT smoking indoors? ☐ Yes ☐ No

Referral Information

Person making referral: ________________________

Waiver Case Manager: ________________________

Phone # ________________________ E-mail: ________________________

Location Desired:

☐ Virginian Court – Customized Living in Crystal (1 & 2 bedrooms)

☐ Vincent – Customized Living in Minneapolis (Efficiency, 1 & 2 bedrooms)

Mental Health Data

Have you been diagnosed with a mental illness? ☐ Yes ☐ No (If yes, complete the following questions)

What is your diagnosis? Primary: ________ Secondary: ______________________________

Others: ____

Are you on a JARVIS or Commitment? ☐ Yes ☐ No If yes, which one? ____________________________

Case manager: ________________________ Phone#: ____________________________

Chemical Health Data

Have you been diagnosed or treated for Chemical Dependency? ☐ Yes ☐ No (If yes, complete the following questions)

Have you been in treatment in the last year? ☐ Yes ☐ No

If yes, where: ________________________ Discharge date: ____________________

Current supports *(i.e. AA, NA, drop-in center)* ____

Medical Health Data *(Include copy of medication list) Keep in mind, we are not wheelchair accessible at this time.*

What is your medical diagnosis? ____

Do you have any physical limitations or disabilities? ☐ Yes ☐ No If yes, explain: ______________________

Do you need a physical assist to transfer ☐ Yes ☐ No

Do you need assistance with ADL's? ☐ Yes ☐ No

Can you safely navigate stairs without a device? ☐ Yes ☐ No

Do you require handicap accessible living? ☐ Yes ☐ No

Do you have a basic understanding of kitchen/fire safety? ☐ Yes ☐ No

Do you have a seizure disorder? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If you are diabetic, are you able to check your own blood sugar and administer your own insulin? ☐ Yes ☐ No ☐ N/A

Functional Information

Functional Information: *Recent history (check all that apply over the past 12 months):*	☐ Self-Injurious Behaviors ☐ Physical Aggression ☐ Verbal Aggression ☐ Mental Illness – Hospitalizations ☐ Sexual Coercion or Aggression ☐ Medication Non-Compliance ☐ Drug/Alcohol Abuse ☐ Developmental Disability ☐ High Medical Needs ☐ Suicidal Ideation and/or Attempt

Customized Living Services Desired *(check all that apply)*

- ☐ Housekeeping assistance
- ☐ Laundry assistance
- ☐ Shopping support
- ☐ Medication and treatment administration
- ☐ Medication monitoring and setups
- ☐ Mental Health management
- ☐ Money management & benefit coordination
- ☐ Rep-Payee services
- ☐ Group socialization/activities and or 1:1 socialization
- ☐ Support finding work or volunteering in the community or going back to school
- ☐ Non-medical and medical transportation with appointment coordination
- ☐ Menu planning and food prep support
- ☐ Personal hygiene, dressing, and bathing prompts/reminders
- ☐ Additional needs: ______________________________
- ☐ Are you okay allowing staff to work with you in your apartment on the above services? ☐ Yes ☐ No

Criminal History *(answering yes, will not necessarily disqualify you)*

Have you ever been arrested? ☐ Yes ☐ No

Have you ever been convicted of a crime? ☐ Yes ☐ No

If yes, please state if it was a misdemeanor or a felony. ______________________________

Are you currently on probation? ☐ Yes ☐ No

If yes, Parole Officer's name and phone# ______________________________

Reason for probation or parole? ______________________________

What are the probation requirements (if any) ______________________________

Please list any arrest history, beginning with the most recent:

Arrest Date	Charge	Outcome of Charges

Financial Data

County of financial responsibility: ______________________

Do you receive Medical Assistance? ☐ Yes ☐ No MA Number: MA renewal date:

What type of waiver does the applicant have?	☐ **BI** ☐ **CADI** ☐ Applicant wishes to private pay ☐ Waiver pending – Assessment Date:

Do you currently have a spend down? ☐ Yes ☐ No If yes, what is the monthly amount? ______________

Do you have any current garnishments? ☐ Yes ☐ No If yes, what is the monthly amount? ______________

Any additional financial responsibilities? ☐ Yes ☐ No If yes, what is the monthly amount? ______________

Do you have a rep-payee? ☐ Yes ☐ No If yes, name: ______________________ Phone#: ______________

May we contact your payee for the purpose of discussing your financial situation and to verify income sources? ☐ Yes ☐ No

Do you currently manage your own finances? ☐ Yes ☐ No

Currently the applicant receives the *monthly* amount of *(check all that apply)*			
	☐	MSA	$
	☐	Family Assistance	$
	☐	Food Support	$
	☐	Income from a job	$
	☐	SSI/RSDI/SSDI	$
	☐	Housing Supports *(Formerly GRH)*	$
	☐	GA	$
	☐	Housing Voucher	$
	☐	Other:	$

This space intentionally left blank

Placement History *(Where or with whom have you lived in the last four years. Include In or Out patient sites, Family, IRTS and residential placements.)*

Current Place: ______________________ Move-in date: __________ Date moved out: __________

Contact Name: ______________________ Email: ______________________

Address: ______________________ Phone: __________

Was rent paid on-time: ☐ Yes ☐ No Number of late payments: ____ Lease violations: ☐ Yes ☐ No How many? ____

Complaints by others: ______________________

Reason for leaving:

Place: ______________________ Move-in date: __________ Date moved out: __________

Contact Name: ______________________ Email: ______________________

Address: ______________________ Phone: __________

Was rent paid on-time: ☐ Yes ☐ No Number of late payments: ____ Lease violations: ☐ Yes ☐ No How many? ____

Complaints by others: ______________________

Reason for leaving:

Place: ______________________ Move-in date: __________ Date moved out: __________

Contact Name: ______________________ Email: ______________________

Address: ______________________ Phone: __________

Was rent paid on-time: ☐ Yes ☐ No Number of late payments: ____ Lease violations: ☐ Yes ☐ No How many? ____

Complaints by others: ______________________

Reason for leaving:

Do you owe any money to any of your previous residences? ☐ Yes ☐ No

If yes, please explain: ______________________

Does your current placement require any kind of notice? ☐ Yes ☐ No

If yes, please explain: ______________________

What is your desired move-in date? ______________________

By signing below, I certify that the information included in this form is correct to the best of my knowledge.

Name and relationship of person completing this form:

Printed Name ______________________ Relationship to Applicant ______________________

Signature ______________________ Date ______________________

Applicant:

Signature ______________________ Date ______________________

Other Individual(s) Assisting with the completion of this form:

Printed Name ______________________ Relationship to Applicant ______________________

Signature ______________________ Date ______________________

Printed Name ______________________ Relationship to Applicant ______________________

Signature ______________________ Date ______________________

This space intentionally left blank

Authorization to Obtain or Release Records

Applicants Name: ______________________ Phone: ____________

Date of birth: ______________________

Street Address: ______________________

City: ______________ State: ______ Zip: ________

Guardian Name: ______________ Phone #: ______________

- I may cancel this authorization in writing at any time by contacting Grandma's Place 763-250-2500.
- This authorization is valid for one year after the date I sign it.
- A copy of this authorization is as valid as the original.
- This information may be disclosed to other parties who are entitled to it by law and therefore no longer protected under the privacy rule.
- I understand the information included in this form and communication, both verbal and written that is shared with Grandma's Place prior to an official intake meeting will be used solely to assess and coordinate services.

I Authorize: Grandma's Place to obtain records about me.

To communicate both verbally and in writing with the professionals and family listed below. (*Check all that apply)*

☐ Waiver Case Mgr. ☐ Primary Physician ☐ Psychiatrist ☐ Behavioral Case Mgr.
☐ Act Team ☐ Rep Payee ☐ ARMHS Worker ☐ ILS Worker ☐ Other

Staff Representative: ______________________ Agency: ____________

Phone #: ______________ E-Mail address: ______________

☐ Waiver Case Mgr. ☐ Primary Physician ☐ Psychiatrist ☐ Behavioral Case Mgr.
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Staff Representative: ______________________ Agency: ____________

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Staff Representative: ______________________ Agency: ____________

Phone #: ______________ E-Mail address: ______________

Current Pharmacy

Staff/Representative	Agency/Relationship	Phone	
Address	City	State	Zip

Grandma's Place Pharmacy:

Geritom (Agency/Relationship)	952-854-1190 (Phone)		
10501 Florida Ave. South Address	Bloomington City	MN. State	55438 Zip

Release of all pertinent information. Requesting Records for the following time: for 1 year from date signed

The information may be shared, unless otherwise indicated, orally, in writing, or electronically.

______________________________ ______________
(Individual Authorizing Disclosure) (Date)

____
(Relationship)

Informed Consent Release of Criminal History Data

Please print legibly – Use complete name including middle name

Last Name ___________________________ First Name ____________________ Middle Name _______________

Maiden or Former Name(s) ____

Date of Birth _________________________ Sex (M) or (F) Social Security Number _________________________

Driver's License Number _______________________________ Issuing State ______________________________

Current Address ____

City, State, Zip Code ____

I hereby authorize and grant my informed consent to the Minnesota Bureau of Criminal Apprehension to release to Grandma's Place, Inc. any information contained about me in the Minnesota Computerized Criminal History for housing with services with this agency.

I hereby release the Minnesota Bureau of Criminal Apprehension and Grandma's Place, Inc. from all actions and causes of action, of any kind and nature whatsoever, past, present and future, arising out of the release of information obtained with this consent.

This authorization shall be valid for a period of twelve (12) months from the date of signature.

____ Signature

_____________________________ Date