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: *Grandma's Place is the service provider; however, we have relationships with property managers at two locations. Are you in need of housing, if so, which location is desired.*

☐ Virginian Court – (1 & 2 bedrooms)

☐ Vincent – (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

Services Desired *(check all that apply)*

		Estimated # of hours per week
☐	Housekeeping assistance	
☐	Laundry assistance	
☐	Shopping support	
☐	Medication monitoring and setups	
☐	Mental Health management	
☐	Money management & benefit coordination	
☐	Community participation	
☐	Support finding work or volunteering in the community or going back to school	
☐	Non-medical and medical transportation coordination	
☐	Appointment and provider 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 Outpatient 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: ________________

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☐ Act Team ☐ Rep Payee ☐ ARMHS Worker ☐ ILS Worker ☐ Other

Staff Representative: ______________________ Agency: ____________

Phone #: ______________ E-Mail address: ________________

Current Pharmacy

Staff/Representative	Agency/Relationship	Phone

Address	City	State	Zip

Grandma's Place Pharmacy:

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