EPILEPSY ALLIANCE RESIDENTIAL GROUP HOME APPLICATION

PART I: GENERAL APPLICANT INFORMATION

1. Name _____Phone _____

Address _____

City_____ State_____ Zip Code _____

Date of Birth _____ Social Security # _____

2. References:

Father _____Phone _____

Address _____

Mother _____Phone _____

Address _____

Brother/Sister (Local) _____Phone _____

Address _____

Close Friend/Relative (Local) _____Phone _____

Address _____

3. Why are you interested in the Residential Group Home? _____

_____

4. How did you learn of the Residential Group Home? _____

_____

PART II: MEDICAL HISTORY

Please list all diagnoses: _____

_____

_____

Please list (or include a list) of current medications:_____

_____

_____

_____

Please any past hospitalizations or surgeries (include reason/procedure and date):_____

_____

_____

_____

_____

1. Do you have Epilepsy? _____ At what age did you have your first seizure? _____

2. What were the circumstances of epilepsy onset? _____

_____

3. Are you now taking anti-seizure medication? Yes _____ No _____

If yes, please list the seizure medication(s) you are taking: _____

_____

4. What kind of seizures have you experienced in the past five years? Grand Mal _____

Tonic Clonic _____ Complex Partial _____ Psychomotor _____ Other _____

5. How many seizures have you had in the past year? _____

6. How long has it been since your last seizure? _____

7. During the last five years, how long was your longest seizure-free period? _____

_____

8. What do you think was the most important factor in that control period? _____

_____

9. Who is your general practitioner?

Name _____ Phone _____

Address_____

10. Have you seen a neurologist? Yes _____ No _____

If yes, please list the following information:

Name _____Phone _____

Address _____

11. When was your most recent physical examination? Date _____

Doctor's Name:_____

Problems Found _____

_____

12. What is your Medicare Claim No.? _____

What is your Medicaid Claim No.? _____

13. Please list any other pertinent medical information not mentioned above: _____

_____

_____

PART III: EDUCATIONAL HISTORY

1. Please give the following information about the first school you attended:

Name of School _____

Address _____

Phone _____ Highest Grade Completed _____

Counselor's Name _____

2. Have you ever applied for vocational training? Yes _____ No _____

If yes, please give the following information:

Name of Sponsor:_____

Address: _____

Phone _____ Counselor's Name:_____

3. Have you ever received vocational training? Yes _____ No _____

If yes, please give the following information:

Name of Training Center:_____

Address: _____

Phone _____ Counselor's Name:_____

4. Do you have an educational goal? Yes _____ No _____

If yes, please outline: _____

_____

PART IV: EMPLOYMENT HISTORY

1. Have you ever been employed? Yes _____ No _____

If yes, use the back of this page to list each job held, employer's name, address, phone, name of supervisor on the job, kind of work, how long you worked there, and approximate date you left the job.

2. What is your present source of income? EARNINGS _____ FAMILY _____

S.S.I. _____ OTHER _____

3. What is the total amount of your monthly income? _____

4. Do you have a Medicaid Payback or other type of trust?_____

5. Have you ever received assistance from other agencies? Yes _____ No _____

If yes, please give the following information:

Name of Agency: _____

Address: _____

Phone: _____

Counselor/Worker's Name: _____

6 . Do you have a goal for employment? Yes _____ No _____

If yes, please outline: _____

_____

PART V: PERSONAL DATA

1. What is the most difficult problem with which you currently have to deal?_____

_____

_____

2. At which aspect of your everyday life are you best? _____

_____

_____

3. Do you take care of your own:

Bed?	Yes _____	No _____
Sweeping?	Yes _____	No _____
Dusting?	Yes _____	No _____
Window Cleaning?	Yes _____	No _____
Laundry?	Yes _____	No _____
Cooking?	Yes _____	No _____

4. Have you ever

Been away from home overnight?	Yes _____	No _____
Gone to camp?	Yes _____	No _____
Lived in a dormitory?	Yes _____	No _____
Traveled alone on a bus?	Yes _____	No _____
Gone out alone for work or errand?	Yes _____	No _____
Gone out alone for recreation?	Yes _____	No _____

5. Do you have any hobbies? Yes _____ No _____ If yes, what are they?_____

_____

_____

6. What are your present living arrangements?

With Family _____ Nursing Home _____ Alone _____ Other_____

7. How do you spend your free time? _____

_____

_____

8. Are you currently on any behavior control medication? Yes _____ No _____

If yes, name of medication(s) _____

9. Do you have any acting out behaviors? If so, please describe: _____

_____

_____

10. Describe your worst day. (Please include what might cause this bad day and how you calm down):

_____

_____

_____

_____

I hereby give my permission for the release of any medical, psychological, or social information from the physicians, counselors, or agencies listed throughout this form.

I understand that the above information is needed to provide a thorough understanding of my needs and goal-setting plans and that this information will be treated with confidentiality.

Applicant's Signature _____ Date _____

Printed name_____

<u>Please return completed application to:</u>

Epilepsy Alliance Ohio
ATTN: Residential Director
895 Central Avenue, Suite 550
Cincinnati, Ohio 45202
Fax# 513-721-0799
Phone# 513-721-2905