Name_____ Date_____

Application For Services

Gaston Residential Services, Inc.
905-A North New Hope Road
Gastonia, North Carolina 28054
Telephone 704-861-9280
Fax 704-868-2154

GRS APPLICATION

Please complete application and return to:
Gaston Residential Services, Inc.
905-A N. New Hope Road
Gastonia, NC 28054
Telephone: 704-861-9280
Fax: 704-868-2154

EQUAL HOUSING OPPORTUNITY

REFERRED BY:	DATE OF APPLICATION:

PERSONAL INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:
SOCIAL SECURITY NUMBER:	BIRTH DATE:	PLACE OF BIRTH:
AGE:	SEX: ☐MALE ☐ FEMALE	COUNTY OF LEGAL RESIDENCE:

APPLICANT'S ADDRESS: STREET	CITY	STATE/ZIP

APPLICANT'S TELEPHONE NUMBER:
HOME: CELL/OTHER:

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ MARRIED	CHILDREN: ☐ YES ☐ NO

RELIGIOUS PREFERENCE:

FATHER'S FULL NAME:	MOTHER'S FULL NAME: (INCLUDING MAIDEN NAME)

ADDRESS: (LIST ADDRESS OF BOTH PARENTS IF DIFFERENT) STREET	CITY	STATE/ZIP
STREET	CITY	STATE/ZIP

TELEPHONE NUMBER: (LIST NUMBERS OF BOTH PARENTS IF DIFFERENT)
HOME: CELL: WORK/OTHER:

PLEASE LIST THE NAME, ADDRESS, AND PHONE NUMBERS OF OTHER IMMEDIATE FAMILY MEMBERS WHO CAN BE CONTACTED IN CASE OF EMERGENCY:

NAME: PHONE NUMBER:

ADDRESS: STREET	CITY	STATE/ZIP

LEGAL GUARDIAN (IF APPLICABLE)

FIRST NAME:	LAST NAME:
TYPE OF GUARDIANSHIP:	DATE ESTABLISHED:

ADDRESS: STREET	CITY	STATE/ZIP

TELEPHONE NUMBER:

HOME: CELL/OTHER:

RELATIONSHIP TO APPLICANT:

RESOURCE COORDINATOR (CASE MANAGER)

FIRST NAME:	LAST NAME:

COMPANY NAME:

ADDRESS: STREET	CITY	STATE/ZIP

TELEPHONE NUMBER:

OFFICE: CELL/OTHER:

EMAIL:	COUNTY LME:

SERVICES REQUESTED

☐ RESIDENTIAL
- ☐ OWN HOME
- ☐ APARTMENT

☐ GROUP HOME

- ☐ EMPLOYMENT
- ☐ COMMUNITY SUPPORT SERVICES
- ☐ RESOURCE COORDINATION (CASE MANAGEMENT)

REASONS FOR REQUESTING SERVICES FROM GRS AT THIS TIME:

WHAT SUPPORTS DO YOU NEED THROUGHOUT THE DAY?

LIST THE THINGS YOU LIKE TO DO:

MEDICAL INFORMATION

AXIS I DIAGNOSIS:

AXIS II DIAGNOSIS:

AXIS III DIAGNOSIS:

OTHER DIAGNOSES:

PHYSICIAN:

ADDRESS:

TELEPHONE:

DENTIST:

ADDRESS:

TELEPHONE:

PSYCHIATRIST IF APPLICABLE:

ADDRESS:

TELEPHONE:

DO YOU USE ANY ADAPTIVE EQUIPMENT? ☐ YES ☐NO

PLEASE LIST EQUIPMENT USED:

DO YOU HAVE A SEIZURE DISORDER?: ☐ YES ☐ NO

IF YES, TYPE AND FREQUENCY:

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST THE MEDICATIONS:

DO YOU HAVE ANY OTHER ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE LIST:

CURRENT MEDICATIONS

NAME OF MEDICATION	DOSAGE	REASON FOR USE

If more space is required, please attach a separate list or use the back of this sheet.

ADDITIONAL INFORMATION

HAVE YOU RECEIVED SERVICES/SUPPORTS FROM OTHER PROVIDERS IN THE LAST THREE (3) YEARS?

☐ YES ☐ NO

IF YES, WHO PROVIDED THE SERVICES AND WHICH SUPPORTS/SERVICES WERE RECEIVED:

PLEASE DESCRIBE YOUR CRISIS PLAN:

FAMILY / SOCIAL SUPPORT INFORMATION

WHO LIVES IN YOUR HOME?	RELATIONSHIP TO YOU	AGE

WHAT SUPPORTS WOULD BE NEEDED FOR YOU TO REMAIN IN YOUR CURRENT RESIDENCE?

FINANCIAL INFORMATION

	AMOUNT (MONTHLY)
DO YOU RECEIVE SOCIAL SECURITY INCOME (SSI)? ☐YES ☐ NO	
DO YOU RECEIVE SOCIAL SECURITY DISABILITY INCOME (SSDI)? ☐ YES ☐NO	

DO YOU HAVE A REPRESENTATIVE PAYEE ? ☐YES ☐ NO IF SO, PLEASE GIVE NAME AND ADDRESS:

DO YOU HAVE EMPLOYMENT INCOME? ☐ YES ☐ NO	

INSURANCE INFORMATION

DO YOU HAVE PRIVATE INSURANCE? ☐ YES ☐NO IF SO, GIVE NAME OF COMPANY:	SUBSCRIBER ID/GROUP #:
DO YOU HAVE MEDICAID? ☐ YES ☐ NO MEDICAID NUMBER:	DO YOU HAVE MEDICARE? ☐ YES ☐ NO MEDICARE NUMBER:

EDUCATION INFORMATION

HIGHEST GRADE COMPLETED:

DO YOU HAVE A DIPLOMA? ☐ YES ☐ NO

DO YOU HAVE A GED? ☐ YES ☐ NO

NAME OF EDUCATIONAL INSTITUTION:

DEGREE, DIPLOMA, MAJOR, CERTIFICATION:

WORK HISTORY

INCLUDE U.S. ARMED FORCES EXPERIENCE. YOU MAY INCLUDE ANY VOLUNTEER WORK.

TYPE OF WORK:

EMPLOYER OR VOLUNTEER AGENCY :

SUPERVISOR'S NAME:

TITLE:

PHONE #:

DATES EMPLOYED:

LAST SALARY:

DUTIES:

REASON FOR LEAVING:

TYPE OF WORK:

EMPLOYER OR VOLUNTEER AGENCY:

SUPERVISOR'S NAME:

TITLE:

PHONE #:

DATES EMPLOYED:

LAST SALARY:

DUTIES:

REASON FOR LEAVING:

TYPE OF WORK:

EMPLOYER OR VOLUNTEER AGENCY:

SUPERVISOR'S NAME:

TITLE:

PHONE #:

DATES EMPLOYED:

LAST SALARY:

DUTIES:

REASON FOR LEAVING:

CERTIFICATION

HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☐ YES ☐NO

IF YES, PLEASE EXPLAIN:

I HEREBY GIVE MY CONSENT FOR RELEASE OF ALL MEDICAL INFORMATION AND SOCIAL, VOCATIONAL, AND PSYCHOLOGICAL EVALUATIONS AS NEEDED TO THE GASTON RESIDENTIAL SERVICES ADMISSIONS COMMITTEE FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR PLACEMENT IN THE GASTON RESIDENTIAL SERVICES PROGRAM. I ALSO UNDERSTAND THAT A DRUG AND CRIMINAL CHECK MAY BE PERFORMED PRIOR TO ADMISSION.

SIGNATURE DATE

GUARDIAN (IF APPLICABLE) DATE

PERSON COMPLETING THIS FORM DATE