

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

REFERRED BY:		DATE OF APPLICATION:	
PERSONAL INFORMATION			
FIRST NAME:		MIDDLE NAME:	LAST NAME:
SOCIAL SECURITY NUMBER:		BIRTH DATE:	PLACE OF BIRTH:
AGE:		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	COUNTY OF LEGAL RESIDENCE:
APPLICANT'S ADDRESS: STREET		CITY	STATE/ZIP
APPLICANT'S TELEPHONE NUMBER:			
HOME:		CELL/OTHER:	
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED		CHILDREN: <input type="checkbox"/> YES <input type="checkbox"/> 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

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> RESIDENTIAL | <input type="checkbox"/> EMPLOYMENT |
| <input type="checkbox"/> OWN HOME | <input type="checkbox"/> COMMUNITY SUPPORT SERVICES |
| <input type="checkbox"/> APARTMENT | <input type="checkbox"/> RESOURCE COORDINATION (CASE MANAGEMENT) |
| <input type="checkbox"/> GROUP HOME | |

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:

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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