

Name \_\_\_\_\_

Date \_\_\_\_\_



## **Application For Services**

**GRS Resource Coordination, Inc.  
905-A North New Hope Road  
Gastonia, North Carolina 28054  
Telephone 704-861-9280  
Fax 704-868-2154**



**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:

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:

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I HEREBY GIVE MY CONSENT FOR RELEASE OF ALL MEDICAL INFORMATION AND SOCIAL, VOCATIONAL, AND PSYCHOLOGICAL EVALUATIONS AS NEEDED TO THE GRS RESOURCE COORDINATION 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.

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SIGNATURE

---

DATE

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GUARDIAN (IF APPLICABLE)

---

DATE

---

PERSON COMPLETING THIS FORM

---

DATE