The Haven
4405 Desoto Road, Sarasota, FL 34235
Telephone: 941-355-8808 Fax: 941-355-3898

Date of application:_____

Name:_____ Date of Birth:_____

Full current address:_____ Home phone:_____

Legal status: Legally competent ____*Incompetent _____Type of Guardianship:_____

**If "Incompetent", give name and address) of Court-Appointed Legal Guardian below:*

Name of legal guardian:_____

Full Address:_____ Phone:_____

Contact #1 name:_____Relationship:_____

Full address:_____

Work phone:_____ Home phone:_____

Email:_____

Contact #2 name:_____Relationship:_____

Full address:_____

Work phone:_____ Home phone:_____

Email:_____

Contact #3 name:_____Relationship:_____

Full address:_____

Work phone:_____ Home phone:_____

Email:_____

Services received from Agency for Persons with Disabilities (APD) Yes☐ No☐

Support Coordinator:_____ Contact #:_____

Residential Housing Request:

Check all that apply:

Roommate desired: Yes☐ No☐

Co-ed house:☐Same gender house:☐

Reason for seeking housing: _____

Emergency or crisis situation (if yes please explain): no☐yes:☐

_____

<u>Psychological Evaluation required/ If applicable- Current Behavior Plan required</u>

Behavioral Issues (Describe, if any, i.e. non-compliance, verbal aggression, physical aggression, etc. If applying for Group Home Placement, identify any significant behaviors which could pose a risk to other individuals residing in the home):_____

_____

<u>Ambulatory Status:</u> Wheelchair, Non-Transfer☐ Wheelchair, can Transfer☐ walks with steady gait☐

Walks with unsteady Gait☐ Uses cane/crutch/walker☐ other:☐

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Physical Handicaps: (describe, if any) _____

_____

Adaptive Skills: (if individual requires reminders or prompting—the appropriate column would be Requires Assistance.)

	Independent	Requires Assistance (indicate type)	Requires Staff to complete
Personal Hygiene			
Dressing			
Toileting			
Eating			
Socialization			
Communication Skills			
Community Skills			
Safety Skills			
Medication Admin.			

Assistive Devices: Check all they apply

Hearing aid: ☐ Dentures: ☐ Glasses/contact lens: ☐ Communication device: ☐

Wheelchair: ☐ Walker: ☐ Positioning device: ☐ Other: _____

Present medical concerns and chronic conditions: (Epilepsy, nonverbal, deaf, Cerebral Palsy, Etc.)

_____

_____

If you take medication for seizures, what are the signs of a seizure coming and description of seizures?

_____

Allergies (Drugs, insect bites, food, etc.): _____

_____

History of Hospitalizations during past 2 years and any surgery requiring hospitalization during lifetime:

_____

_____

Current medications: _____

_____

_____

_____

Comments and other helpful information: _____

_____

_____

Form completed by: _____