APPLICATION FOR SERVICES

Services Requested: ☐ Residential (group home, apartment) ☐ Community (AFL, personal home) ☐ Day Services ☐ Employment

Referral Source/Name:	Contact Number:	Application Date:
Referral Address:	E-mail:	

TRANSPORTATION INFORMATION

Check all that apply: ☐ Owns scooter/vehicle ☐ Rides/Has bicycle ☐ Walks ☐ Uses public transportation ☐ None

PERSONAL IDENTIFICATION OF APPLICANT

First Name:	Middle:	Last:
Address:		
Home MCO:	County:	Social Security #:
Gender:	Date of Birth:	Race:
Phone Number:	Known Allergies:	
Insurance Information (check all that apply)	☐ Medicaid ☐ Medicare ☐ No Insurance ☐ Private Insurance (specify): _______	

GUARDIAN INFORMATION

☐ Person does not have guardian, N/A (skip this section)

Name:	**Address:**	
Type of Guardianship:	Relationship to Applicant:	Phone Number:
Fax Number:	Email:	Other:

GENERAL HEALTH/MEDICAL INFORMATION

Do you have a primary care physician? ☐ Yes ☐ No   Have you had a physical exam in the past 12 months? ☐ Yes ☐ No

If yes, name of provider/practice: ________________________   Please provide as much contact information as you can. Thank you!

Address: ________________________   Phone Number: ________________________

________________________   Fax Number: ________________________

Are you currently experiencing any of the following health problems?

Diabetes	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Hearing Problems	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Nausea/Vomiting	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Muscle/joint Problems	☐ Yes ☐ No	Change in Appetite	☐ Yes ☐ No		
Other Medical Problems	☐ Yes ☐ No	Explain:			

If yes to any above, is person being treated by a healthcare professional for the condition? ☐ Yes ☐ No ***(Internal: If no, make referral)***

Do you use tobacco? ☐ Yes ☐ No   Are you interested in stopping? ☐ Yes ☐ No ☐ N/A

Medication Name	**Dose (mg)?**	**How often?**	**Last Use (Date)?**	**Who Prescribed?**	**Taken as prescribed**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Health Comments:

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SELF-CARE INFORMATION

Dining:	☐ Independent	☐ Minimal Assistance	☐ Maximum Assistance	☐ Must be fed
Bathing:	☐ Independent	☐ With Assistance	☐ Full Assistance	☐ Resistant
Ambulation:	☐ Independent	☐ Semi-ambulatory	☐ Self propels	☐ Dependent
Dressing:	☐ Independent	☐ Verbal cues	☐ Physical prompts	☐ Full assistance
Communication:	☐ Independent	☐ Non-verbal	☐ Symbol Board	☐ Gestures
Toileting:	☐ Independent	☐ Toilet schedule	☐ Incontinent	
Sleeping Habits:	☐ Sleeps all night	☐ Gets up on occasion	☐ Trouble sleeping	

Self-Care Comments:

FINANCIAL

☐ Able to budget ☐ Financially responsible ☐ Unable to budget ☐ Pattern of reckless spending ☐ Financial stress

☐ Significant debt ☐ Has filed for/declared bankruptcy ☐ Stable income ☐ Flexible/unstable income ☐ No income

FAMILY/SOCIAL SUPPORTS/LIVING SITUATION

Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Annulled ☐ Domestic Partners ☐ Unknown	**Number of Children**	
Family/Friend Support	☐ All support ☐ Some support ☐ No support ☐ No family/friends ☐ Family/friends don't know		
Involvement in faith/religious activity	☐ Attends regularly (strength) ☐ Occasional attendance ☐ No attendance ☐ N/A		
Other Areas of Concern	☐ Family desertion ☐ Child neglect ☐ Child abuse ☐ Running away ☐ Separation or divorce ☐ Custody disputes ☐ Domestic violence ☐ Conflicts with family/friends ☐ Recent death in family/friend		
Persons Living in Household (#)		**Describe**	
Current Living Arrangements	☐ Private Residence ☐ Homeless ☐ Correctional Facility ☐ Residential Facility ☐ Foster Family/AFL ☐ Nursing Home ☐ Adult Care Home (7+ beds) ☐ Adult Care Home (6 or fewer beds) ☐ Other: ____________		

Comments:

SOCIAL ROLE/BEHAVIOR

☐ None	☐ Limited use of community resources	☐ Poor impulse control	☐ Fighting
☐ Isolation worsens symptoms	☐ Lacks activity	☐ Probation	☐ Promiscuity/Exhibitionism
☐ Fabricates truth	☐ Uncomfortable around others	☐ Social isolation	☐ On probation/parole
☐ Destroys property	☐ Stealing	☐ Anxiety in relationships	☐ Legal problems

Social Role/Behavior Comments:

EMPLOYMENT/MILITARY/EDUCATION

Current Employment	☐ Full Time ☐ Part Time ☐ Homemaker ☐ Unemployed ☐ On disability ☐ Retired ☐ Student
If yes, where/what type of work?	
If no, is person interested in work? ☐ Yes ☐ No	☐ Current job pays at least minimum wage ☐ Person is underemployed
Person/Family Military Service	☐ N/A ☐ Active military/national guard ☐ Family member in military/natural guard ☐ Wounded in combat ☐ Operation Enduring Freedom ☐ Operation Iraqi Freedom ☐ Other Combat (specify): ________________

☐ Currently enrolled If yes, where? ____

☐ Completed high school/Earned GED ☐ Some college ☐ Certificate Earned ☐ Complete college (degree earned): ____________

Interest in Continuing Education	☐ Yes ☐ No	IQ Testing Completed?	☐ Yes ☐ No (If yes, request a copy of report)
Please check all that apply:	☐ I have a hard time learning new concepts/ideas.	☐ I have been diagnosed with a learning disability.	
	☐ I have or had an IEP (Individualized Education Plan) or 504 Plan.		

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TALENTS, INTERESTS & HOBBIES (please list)
Employment/Military/Education Comments:

Legal History

☐ I have never been in trouble with the law. (Please skip this section)

☐ I have open/active court cases — If so, what are the charges? ________
☐ I am currently scheduled for court — If so, when is your court date? ________
☐ I am currently on probation — If so, until when? ________
☐ I have spent time in prison/jail — If so, when and for how long? ________
☐ I am under legal pressure to attend this program. — If so, from whom? ________

If yes, would you be attending the program without this pressure? ☐ Yes ☐ No

Do you think your legal involvement will impact your ability to make progress in treatment? ☐ Yes ☐ No (please indicate reason in comments)

Prior Convictions (felony or misdemeanor)	**Number of arrests**	**Most Recent Date**

Comments: ________

PSYCHIATRIC ADVANCE DIRECTIVE		
Does the applicant have a Psychiatric Advance Directive?	☐ Yes ☐ No	***If yes, please attach a copy to application.***
If applicant does not have a psychiatric advance directive, would he/she like further information about it?	☐ Yes ☐ No	

DIAGNOSIS

Class	Code/Description

Please submit completed application along with the following documentation:

☐ Current Person-Centered Plan or Treatment Plan from current service provider
☐ Current Comprehensive Clinical Assessment (If applying for a mental health service or location)
☐ Psychological Evaluation (If applying for a service or location for Intellectual and Developmental Disabilities)
☐ Psychiatric Advance Directive (if applicable)
☐ Documentation of Legal Guardianship (if applicable)
☐ Copy of Medicaid Card (if applicable)

Please submit all information electronically to Referral Coordinator at referrals@monarchnc.org.

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↓↓↓↓↓ FOR INTERNAL/OFFICE USE ONLY THIS POINT FORWARD ↓↓↓↓↓	
Date application received:	**Date forwarded to DPO:** **Name of DPO:**
Date Tour scheduled:	**Date of Selection Committee:**

Outcome of Selection Committee:
☐ Accepted: Move-in date: ________________________
☐ Not accepted for following reason (choose from below):
    ☐ Does not meet service criteria
    ☐ Another applicant chosen
    ☐ Funding (MCO will not approve)
    ☐ Individual/Family/Legally responsible person choice
	Waitlist:
	☐ Yes
	☐ No
	
	Risk of Harm Reviewed:
	☐ No current risk
	☐ Referral made
	☐ Involuntary commitment initiated