Dear

Thank you for your interest in Stillwater Group Homes, Inc. Enclosed you will find an application for services and other necessary information pertaining to eligibility. Below is a checklist of items that should accompany the application.

If you have any questions regarding the application process, services we provide, etc. please feel free to contact our office. We will set up an appointment to begin programming.

Again, thank you for your interest in our agency. We look forward to meeting with you.

Sincerely.

Janet Lynn

Executive Director

- Individual Plan
- Current Physical Examination
- Copy of Social Security Card
- Copy of Birth Certificate
- Copy of Guardianship Information, if applicable
- Signed Release of Information Form

STILLWATER GROUP HOMES, INC.
904 W. 11TH
STILLWATER, OK 74074

GENERAL ADMISSIONS AND ELIGIBILITY REQUIREMENTS

1. Applicant must be at least eighteen (18) years of age at the time of admission.
2. Applicant must have a primary diagnosis of Mental Retardation.
3. Applicant must be eligible for services by the Developmental Disabilities Services Division of the Department of Human Services.

MISSION STATEMENT

Stillwater Group Homes, Inc. was established to provide residential and vocational services and training for adults with developmental disabilities so that they may function as independently as possible in the least restrictive environment to meet their needs. All individuals served are treated and respected as adults at all times. The staff is responsible for assisting each individual in recognizing his/her rights as adults and as citizens. At all times, this agency will be committed to meeting the highest standards possible in its provision of services.

POLICY CONCERNING DISCRIMINATION

This agency does not discriminate in any personnel or programming policy or practice. Discrimination against an applicant, employee, or consumer because of race, creed, color, ethnic or national origin, age, veteran status, sex, sexual orientation, or disability is prohibited.

APPLICATION FOR SERVICES

Application being submitted for what services (check one)

____ Group Homes ____ Assisted Living ____ Supported Living ____ Respite Care

____ Vocational ____ Daily Living Supports ____ HTS

Date of Application: ____________________

Contact Person: ____

Present Address: ____

Telephone Number: (______)________________________________

PERSONAL INFORMATION

Full Name of Applicant: ______________________________

Present Address: ______________________________

Telephone Number: (______) ______________________

Date of Birth: ______________ Place of Birth: ______________

Age: ________ Sex: ________ Height: ________ Weight: ________

Hair Color: ________ Eye Color: ________ Marital Status: ________

FAMILY COMPOSITION

Contact Person(s) ______________________________

Address: ______________________________

Home Phone: (______) ______________ Work Phone: (______) ______________

In case of emergency contact ______________________________

Relationship: ______________ Phone: (______) ______________

Address: ______________________________

IMMEDIATE FAMILY

Names	Relationship	Phone

LEGAL STATUS

Is applicant own legal guardian? ______ Yes ______ No

If "NO", list name of Guardian ______________________________

Address: ______________________ Phone: (______) ______________

LATEST PSYCHOLOGICAL TESTING (Attach copy of psychological summary)

IQ Level: ____________________ Date Tested: ____________________

Diagnosis: ____

Any Secondary Diagnosis: ____

APPLICANT'S SOURCE OF INCOME (check all that apply)

_____ SSI Amount $_______________ _____ DHS $ _______________

_____ Social Security $_______________ _____ VA $ _______________

_____ R.R. $ _______________ _____ Money from trust $ _______________

_____ Employment $ _______________ Where Employed: ____________________

_____ Other Income $ _______________

Medicare Number (attach copy of card): ____

Medicaid Number (attach copy of card): ____

Does applicant have private insurance? _____ Yes _____ No

Name of Company: ______________________________ Policy #: ____________________

RELIGIOUS PREFERENCE ____

Member of Church: ____
(Name) (Address)

PREVIOUS PLACEMENTS (if any) List places where applicant has lived

Name of Facility or School: ____

Dates of Residence: ____________________________ Phone # (_____)_______________

Address: ____

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Name of Facility or School: ____

Dates of Residence: ____________________________ Phone # (_____)_______________

Address: ____

Name of Facility or School: ____________________

Dates of Residence: ____________________ Phone # (____) ____________

Address: ____________________

HISTORY OF EMPLOYMENT – include Sheltered Workshop employment also

Place of Employment: ____________________

Dates of Employment: ____________ Supervisor: ____________

Place of Employment: ____________________

Dates of Employment: ____________ Supervisor: ____________

GENERAL INFORMATION

Reasons for seeking placement in our program: ____________________

Has applicant ever been convicted of a misdemeanor or felony? ____________

Does applicant have a history of alcohol or drug abuse? ____________

Does applicant exhibit aggressive or potentially dangerous behavior? ____________

Does applicant attempt to hurt him/herself when upset? ____________

Does applicant destroy property when upset? ____________

Does applicant run away or wander off either on purpose or by accident? ____________

Is applicant sexually active? ______ Yes ______ No

How does applicant respond to members of the opposite sex? ____________

____

How does applicant relate to peers? ____

How does applicant relate to authority figures? ___________________________________

Does applicant lose temper easily? ____

Does applicant assume responsibility for household chores? _______________________

____

The age the applicant became developmentally disabled (birth, two years old, etc.)________

____

DAILY LIVING SKILLS

Does applicant feed self without assistance?	_____ Yes	_____ No
Attend to toilet without assistance?	_____ Yes	_____ No
Control bladder during the night?	_____ Yes	_____ No
Take care of menstrual needs?	_____ Yes	_____ No
Dress and undress without assistance?	_____ Yes	_____ No
Bathe without assistance?	_____ Yes	_____ No
Shave without assistance?	_____ Yes	_____ No
Can applicant express needs to others?	_____ Yes	_____ No
Can applicant tell time?	_____ Yes	_____ No
Can applicant count money?	_____ Yes	_____ No
Can applicant keep a checkbook?	_____ Yes	_____ No
Can applicant use a telephone without assistance?	_____ Yes	_____ No
Express self in complete sentences?	_____ Yes	_____ No
Does applicant have normal hearing?	_____ Yes	_____ No
Does applicant use a hearing aid?	_____ Yes	_____ No
Does applicant have normal vision?	_____ Yes	_____ No
Does applicant wear corrective lenses?	_____ Yes	_____ No

Explain or describe reasons for above answers: _____________________________________

____

____

____

____

MEDICAL HISTORY AND CURRENT NEEDS

Current Medications and Dosages:

_____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

Physician's Name: ______________________________ Phone # (_____)______________
Address: ____

- -

Dentists Name: ______________________________ Phone # (_____)______________
Address: ____

- -

Optometrist's Name: ______________________________ Phone # (_____)______________
Address: ____

- -

Explanation of Medical History: ____

____

____

____

____

Date of last tetanus shot: ____________________

Please attach copy of Immunization Record if available.

List other services/evaluations the applicant has received or is currently receiving (Hospitals, Clinics, Psychologists, Speech Therapists or Occupational Therapists, etc.)

Names	Address	Date

The Screening Committee of Stillwater Group Homes, Inc. will examine all information contained in this application for the purpose of accepting/referring this applicant for the appropriate services. All information is considered confidential.

I/We certify that the information contained herein is complete and accurate and agree to abide by all applicable guidelines for services rendered.

Name of person completing application: ____

______________________________________ ____________________
Signature of Legal Guardian, Parent, Advocate Date

______________________________________ ____________________
Signature of Applicant Date