Intake Application

Instructions: It is important that you complete this form in its entirety. If information is unknown or does not apply to the individual, please fill in the applicable fields with **unknown** or **N/A**. Do not leave any blank fields. If you have any questions, please contact Amy Perez at 763-331-8471.

PART A: PERSONAL INFORMATION (*applicant should fill out this area, may use assistance)*			
First Name:	**Last Name:**		**Middle Initial:**
Current Residence:			
Address:			
City:	**State:**		**Zip:**
Date of Birth:	**Age:**	☐ **MALE** ☐ **FEMALE**	**Primary Language Spoken:**
Daytime Contact Phone Number:		**Evening Contact Phone Number:**	
List all present diagnoses: (Attach a copy of current med list) (Please keep in mind, we are not wheel chair accessible at this time)			

Is the applicant pregnant?	☐ Yes – When is the due date? _____ ☐ No
Do you currently live with a parent, family member or guardian?	☐ No ☐ Yes
Do you have any pets?	☐ Yes ☐ No *If yes, is this pet a certified/registered therapy pet?*
Do you have a driver's license?	☐ Yes ☐ No
Do you own a vehicle?	☐ Yes ☐ No

PART B: LEGAL BACKGROUND (answering yes, will not necessarily disqualify you)	
Has applicant ever been arrested?	☐ Yes ☐ No
Has applicant ever been convicted of a crime? *If yes, please state if it was a misdemeanor or a felony. Describe and include dates and status of all cases.*	☐ Yes ☐ No

Is the applicant currently on probation? *Name and phone number of officer*	☐ Yes ☐ No
Is applicant currently on parole? *Name and phone number of officer*	☐ Yes ☐ No
What are the applicant's probation requirements (if any)	
Is applicant on a commitment order?	☐ Yes ☐ No

PART C: FINANCIAL

What type of waiver does the applicant have?	☐ **BI** ☐ **CADI** ☐ Applicant wishes to private pay ☐ Waiver pending – Assessment Date:		
Currently the applicant receives *(check all that apply)*	☐	MSA	$ /Month
	☐	Cash Assistance	$ /Month
	☐	Food Support	$ /Month
	☐	Income from a job	$ /Month
	☐	SSI	$ /Month
	☐	RSDI	$ /Month
	☐	SSDI	$ /Month
	☐	Adoption Assistance	$ /Month
	☐	Trust	$ /Month
	☐	GRH	$ /Month
	☐	Alimony	$ /Month
	☐	Child Support	$ /Month
	☐	GA	$ /Month
	☐	MFIP	$ /Month
	☐	Unemployment	$ /Month
	☐	Worker's Compensation	$ /Month
	☐	Other:	$ /Month
Currently applicant *(check all that apply)*	☐ Manage their own finances ☐ A family member/friend help them manage finances ☐ Has Rep-Payee *Name* _____ *Rep-Payee phone #* _____ *Rep-Payee E-mail*		

PART E: REFERRAL INFORMATION *(Please provide below information OR attach county referral form)*	
How immediate is placement needed? *(If less than 4 weeks, why?)*	
Waiver case manager *(name)*	
Phone number	
E-Mail address	
Person making referral	
Relationship to applicant	
Living arrangement sought *(Currently we only offer services in Hennepin and Wright Counties)*	☐ Supported Living Services ☐ Customized Living Services ☐ Other, explain

PLACEMENT HISTORY *(Where or with whom have you lived in the last four years. Include In or Out patient sites, Family, IRTS and residential placements.)*

Current Place: _____ Start date: _____ End Date: _____
Contact Name: _____ Email: _____
Address: _____ Phone: _____

Place: _____ Start date: _____ End Date: _____
Contact Name: _____ Email: _____
Address: _____ Phone: _____

Place: _____ Start date: _____ End Date: _____
Contact Name: _____ Email: _____
Address: _____ Phone: _____

Functional Information: *Recent history (check all that apply over the past 12 months):*	☐ Self-Injurious Behaviors ☐ Physical Aggression ☐ Verbal Aggression ☐ Mental Illness – Hospitalizations ☐ Sexual Coercion or Aggression ☐ Medication Non-Compliance ☐ Drug/Alcohol Abuse ☐ Developmental Disability ☐ High Medical Needs ☐ Suicidal Ideation and/or Attempt

By signing below, I certify that the information included in this form is correct to the best of my knowledge.

Name and relationship of person completing this form:

Printed Name _____ Relationship to Applicant _____

Signature _____ Date _____

Applicant:

Signature _____ Date _____

Other Individual(s) Assisting with the completion of this form:

Printed Name _____ Relationship to Applicant _____

Signature _____ Date _____

Printed Name _____ Relationship to Applicant _____

Signature _____ Date _____

Authorization to Obtain or Release Records

Please fax completed form to our fax line at: **763-999-8657**.

Applicants Name: ______________________ Phone: ______________

Date of birth: ______________________

Street Address: ____

City: ____________________ State: ________ Zip: __________

Guardian Name: ____________________ Phone #: ____________________

- I may cancel this authorization in writing at any time by contacting Grandma's Place requesting form #HC12025 if the action it allows has not been carried out.
- This authorization is valid for one year after the date I sign it.
- A copy of this authorization is as valid as the original.
- This information may be disclosed to other parties who are entitled to it by law and therefore no longer protected under the privacy rule.
- I understand the information included in this form and communication, both verbal and written that is shared with Grandma's Place prior to an official intake meeting will be used solely to asses and coordinate services.

I Authorize: Grandma's Place to obtain records about me.

To communicate both verbally and in writing with the professionals and family listed below. (*Check all that apply)*

☐ Waiver Case Mgr. ☐ ARMHS Worker ☐ ILS Worker ☐ Behavioral Case Mgr.
☐ Act Team ☐ Other:

Staff Representative: ______________________ Agency: ______________

Phone #: ______________ E-Mail address: ____________________

☐ Waiver Case Mgr. ☐ ARMHS Worker ☐ ILS Worker ☐ Behavioral Case Mgr.
☐ Act Team ☐ Other:

Staff Representative: ______________________ Agency: ______________

Phone #: ______________ E-Mail address: ____________________

☐ Waiver Case Mgr. ☐ ARMHS Worker ☐ ILS Worker ☐ Behavioral Case Mgr.
☐ Act Team ☐ Other:

Staff Representative: ______________________ Agency: ______________

Phone #: ______________ E-Mail address: ____________________

☐ Psychiatrist ☐ Psychologist ☐ CNP, CNS or PA prescribing psych meds
☐ Therapist ☐ Counselor

Staff Representative: _____ Agency: _____

Phone #: _____ E-Mail Address: _____

☐ Primary Care Physician ☐ Specialist

Staff Representative: _____ Agency: _____

Phone #: _____ E-Mail Address: _____

☐ REP PAYEE

Staff Representative: _____ Agency: _____

Phone #: _____ E-Mail Address: _____

Current Pharmacy:

Staff/Representative	Agency/Relationship	Phone	
Address	City	State	Zip

Grandma's Place Pharmacy:

Geritom	952-854-119		
(Agency/Relationship)	(Phone)		
10501 Florida Ave. South	Bloomington	MN.	55438
Address	City	State	Zip

Release of all pertinent information. Requesting Records for the following time: for 1 year from date signed

The information may be shared, unless otherwise indicated, orally, in writing, or electronically.

_____ _____

(Individual Authorizing Disclosure) (Date)

_____

(Relationship)

Informed Consent Release of Criminal History Data

Please print legibly – Use complete name including middle name

Last Name _____ First Name _____ Middle Name _____

Maiden or Former Name(s) _____

Date of Birth _____ Sex (M) or (F) Social Security Number _____

Driver's License Number _____ Issuing State _____

Current Address _____

City, State, Zip Code _____

I hereby authorize and grant my informed consent to the Minnesota Bureau of Criminal Apprehension to release to Grandma's Place, Inc. any information contained about me in the Minnesota Computerized Criminal History for housing with services with this agency.

I hereby release the Minnesota Bureau of Criminal Apprehension and Grandma's Place, Inc. from all actions and causes of action, of any kind and nature whatsoever, past, present and future, arising out of the release of information obtained with this consent.

This authorization shall be valid for a period of twelve (12) months from the date of signature.

Signature _____ Date _____