**EPILEPSY ALLIANCE RESIDENTIAL GROUP HOME APPLICATION**

PART I: GENERAL APPLICANT INFORMATION

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. References:

Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother/Sister (Local) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Close Friend/Relative (Local) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Why are you interested in the Residential Group Home? \_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. How did you learn of the Residential Group Home? \_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_

PART II: MEDICAL HISTORY

Please list all diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list (or include a list) of current medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please any past hospitalizations or surgeries (include reason/procedure and date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have Epilepsy? \_\_\_\_\_\_\_\_\_\_\_ At what age did you have your first seizure?

2. What were the circumstances of epilepsy onset? \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you now taking anti-seizure medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list the seizure medication(s) you are taking: \_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What kind of seizures have you experienced in the past five years? Grand Mal \_\_\_\_\_

Tonic Clonic \_\_\_\_\_ Complex Partial \_\_\_\_\_ Psychomotor \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. How many seizures have you had in the past year? \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

6. How long has it been since your last seizure? \_\_\_\_\_\_\_

7. During the last five years, how long was your longest seizure-free period? \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. What do you think was the most important factor in that control period? \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Who is your general practitioner?

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Have you seen a neurologist? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list the following information:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. When was your most recent physical examination? Date

Doctor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems Found \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. What is your Medicare Claim No.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your Medicaid Claim No.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Please list any other pertinent medical information not mentioned above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PART III: EDUCATIONAL HISTORY

1. Please give the following information about the first school you attended:

Name of School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Grade Completed \_\_\_\_\_\_\_

Counselor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

2. Have you ever applied for vocational training? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give the following information:

Name of Sponsor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Counselor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you ever received vocational training? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give the following information:

Name of Training Center: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Counselor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you have an educational goal? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please outline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PART IV: EMPLOYMENT HISTORY

1. Have you ever been employed? Yes \_\_\_\_\_ No \_\_\_\_\_

 If yes, use the back of this page to list each job held, employer’s name, address, phone, name of supervisor on the job, kind of work, how long you worked there, and approximate date you left the job.

2. What is your present source of income? EARNINGS \_\_\_\_\_\_\_ FAMILY \_\_\_\_\_\_\_

S.S.I. \_\_\_\_\_\_\_ OTHER

3. What is the total amount of your monthly income?

4. Do you have a Medicaid Payback or other type of trust?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Have you ever received assistance from other agencies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give the following information:

Name of Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Counselor/Worker’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

6 . Do you have a goal for employment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please outline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PART V: PERSONAL DATA

1. What is the most difficult problem with which you currently have to deal?\_\_\_\_\_\_ \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. At which aspect of your everyday life are you best? \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you take care of your own:

 Bed? Yes \_\_\_\_\_ No \_\_\_\_\_

 Sweeping? Yes \_\_\_\_\_ No \_\_\_\_\_

 Dusting? Yes \_\_\_\_\_ No \_\_\_\_\_

 Window Cleaning? Yes \_\_\_\_\_ No \_\_\_\_\_

 Laundry? Yes \_\_\_\_\_ No \_\_\_\_\_

 Cooking? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Have you ever

 Been away from home overnight? Yes \_\_\_\_\_ No \_\_\_\_\_

 Gone to camp? Yes \_\_\_\_\_ No \_\_\_\_\_

 Lived in a dormitory? Yes \_\_\_\_\_ No \_\_\_\_\_

 Traveled alone on a bus? Yes \_\_\_\_\_ No \_\_\_\_\_

 Gone out alone for work or errand? Yes \_\_\_\_\_ No \_\_\_\_\_

 Gone out alone for recreation? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Do you have any hobbies? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. What are your present living arrangements?

 With Family \_\_\_\_\_\_\_ Nursing Home \_\_\_\_\_\_\_ Alone \_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

7. How do you spend your free time? \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Are you currently on any behavior control medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name of medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Do you have any acting out behaviors? If so, please describe: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

10. Describe your worst day. (Please include what might cause this bad day and how you calm down):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 I hereby give my permission for the release of any medical, psychological, or social information from the physicians, counselors, or agencies listed throughout this form.

 I understand that the above information is needed to provide a thorough understanding of my needs and goal-setting plans and that this information will be treated with confidentiality.

Applicant’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return completed application to:

 Epilepsy Alliance Ohio

 ATTN: Residential Director

895 Central Avenue, Suite 550

Cincinnati, Ohio 45202

Fax# 513-721-0799

Phone# 513-721-2905