Application for Admission to Glory Community

Thank you for your interest in Glory Community. The purpose of this application is not to disqualify someone, but rather to understand the family's interest. The application will not be considered unless it is completed and returned with:

- Picture of the potential resident
- Medical history
- Most recent psychological and/or psychiatric evaluation
- Any additional information you deem important for full and accurate evaluation
- $100 nonrefundable application fee.

The Admissions Committee conducts a thorough study of the information provided, determines the placement availability and suitability of each applicant, and notifies you whether or not the applicant will be advanced to the next step of the application process. If you have any questions, please do not hesitate to call us at 303 410 9699.

LETTER OF INTEREST

I understand the following criteria for admission to Glory Community and our applicant wishes to be considered for the application process:

1) Age 22 and over
2) Has been diagnosed with developmental disabilities with no history of severe behavioral/emotional issues
3) Capable of four to six hours/day employment, five days/week
4) Applicant is capable of self care with minimal assistance, but needs help negotiating life
5) Family is able to meet monthly financial obligation

I understand Glory Community is open to all faiths, but it will be operated in a Christian environment, based on Christian values and principles. Glory Community admits applicants of any race, color, national or ethnic origin.

____ ________________
Signature of Parent/Guardian Date

Please describe your goals and expectations for the applicant and what you hope Glory Community can accomplish towards this end:

How soon are you seeking enrollment in Glory Community?
_________As soon as possible
_________In (which year going forward)_____________

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Applicant's Full Name Date of Birth

Address of Applicant City/State/Zip

Telephone Social Security Number Male or Female

Height Weight Age

Name of Mother Email Address Telephone

Address City/State/Zip

Occupation/Name of Company Business Email Business Telephone

Name of Father Email Address Telephone

Address City/State/Zip

Occupation/Name of Company Business Email Business Telephone

Legal Guardian (Other than parents) Relationship

Home Address City/State/Zip

Occupation/Name of Company Email Business Telephone

Home Telephone Email Cell Phone

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Names/Ages/Telephone of Applicant's Siblings:

1____

2____

3____

4____

PLEASE LIST FAMILY REFERENCES IN THE FOLLOWING CATEGORIES:

1) Personal (Friend, Neighbor, Pastor, etc)

Name Home Telephone Email

Address City/State/Zip

2) Professional (Co-worker, Colleague, etc)

Name Home Telephone Email

Address City/State/Zip

3) Financial (Banker, Financial Planner, etc)

Name Home Telephone Email

Address City/State/Zip

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Is applicant receiving SLS funding: ____Yes ____No

What is applicant's medical insurance coverage:________________________________

____

Is applicant currently employed: ____Yes ____No. If yes, where and what are the hours employed: ____

____

CHECK ALL SITUATIONS IN WHICH THE APPLICANT HAS PARTICIPATED

_____Graduated Public Education __Yes__No

_____Private School

_____Competitive Employment

_____Sheltered Workshop

_____Group Home

_____Independent Living

_____Host Home (how many?_____)

_____Education beyond high school

_____Other (explain)

PLEASE COMPLETE THE FOLLOWING INFORMATION ON EACH PROGRAM (use back of this page if more space in needed)

1) ____

Name Dates

____

Address City/State/Zip

____

Type of situation (refer to list above)

____

Reason for leaving

____

Contact person for additional information Telephone

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2) ____

Name Dates

____

Address City/State/Zip

____

Type of situation (refer to above list)

____

Reason for leaving

____

Contact person for additional information Telephone

3) ____

Name Dates

____

Address City/State/Zip

____

Type of situation (refer to list above)

____

Reason for leaving

____

Contact person for additional information Telephone

4) ____

Name Dates

____

Address City/State/Zip

____

Type of situation (refer to above list)

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Reason for leaving

Contact person for additional information Telephone

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) Please describe applicant's general health, including special medical problems and/or physical disabilities.

2) Please describe applicant's communication abilities. (consider expressive and receptive)

3) Please describe applicant's social/emotional state most of the time (e.g. withdrawn, hyper-verbal, frustrated, sociable, even-tempered, outbursts or meltdowns)

4) Does he/she prefer to be with peers, family, someone older or alone? Please explain.

5) Please describe applicant's self-help skills. What does someone need to do daily to help the applicant? Consider personal hygiene, grooming, eating, etc. (can use back of this page for additional comments)

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6) Please describe applicant's daily routines and leisure activities:

7) What do you see the applicant's functional disabilities to be? (Consider self care, learning, mobility, language, self direction, capacity for independent living)

8) What do you think applicant feels are his/her abilities and disabilities?

9) What are the applicant's specific aptitudes, interests, and/or strengths?

10) Has the applicant ever been involved with any of the following?

Tobacco	___yes	___no	(if yes, please explain on back)
Drug Abuse	___yes	___no	“”
Criminal Activity	___yes	___no	“”
Sexual Misconduct	___yes	___no	“”

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11) Please describe activity areas and/or situations that the applicant likes and dislikes:

12) Describe applicant's learning style. (e.g. visual learner, auditory, etc.) (consider cognition, memory retention, reasoning skills, reading and writing skills,)

13) What types of assistance does applicant use for mobility, for learning, or for health. (e.g. language assistance, walker, wheelchair, apnea machine, etc.)

14) What type of help does applicant need in making decisions concerning their personal or social life. (consider emotional development, fears, anxieties, frustrations, interpersonal relations, managing personal finances or routine medical care)

16) What are the independent skills of the applicant?

Household tasks such as: bed making ___Y __N/ Putting dishes in dishwasher __Y __N/ Vacuuming __Y __N/ Cleaning own room __Y __N/ Cleaning bathroom __Y __N/ Helping with meal preparation __Y __N

Any cooking skills? Please list;____

____

Travel alone on the RTD __Y __N

Can use telephone __Y __N/ Can use computer __Y __N

Understands "House Rules" __Y __N

List other skills:

____

Please list three individuals (different from those listed on page 3) who have worked with or known the applicant very well:

(1)

Name Email Cell Phone

Address City/State/Zip

(2)

Name Email Cell Phone

Address City/State/Zip

(3____

Name Email Cell Phone

Address City/State/Zip

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Please read and sign:

I affirm that the preceding information is a complete and true statement of all the facts and circumstances relative to this applicant's application for enrollment in Glory Community.

We, the undersigned, do give our permission for Glory Community to contact any and all of the references, programs, schools, and professionals listed on this application.

____ __________________

Signature of Parent/Guardian Date

____ __________________

Signature of Applicant (if appropriate) Date

____ __________________

Signature of person completing this application if other Than parent or guardian and relationship to applicant Date

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GLORY COMMUNITY MEDICAL HISTORY

This part of the form must be completely filled out by parents or guardians. Information must be typed or printed. If answer is "no" or "none", please indicate by writing "no".

Applicant's Name_______________________________________Birth Date__________

Address____Telephone__________

IMMUNIZATION RECORD

	DATE	
Measles		Must have had or been vaccinated with live vaccine since 1968
Mumps		Must have had or been vaccinated with live vaccine after 12 months of age
Rubella		Must have had or been vaccinated after 12 months of age
Tetanus & Diptheria		Series of 3 doses – second dose 4-8 weeks after 1st dose: third dose 6-12 months after second dose
Tetanus Booster		Should be given every 10 years. Please give date of last booster
Polio – indicate OPV or IPV		Series of Trivalent Oral Polio (OPV) vaccine at 2,4 and 18 months of age; or if taken 4 doses of Inactive Polio Vaccine (IPV), continue IPV every 5 years until 18 years old. List 3 last 3 vaccinations.
Tuberculosis		Negative chest x-ray or Tine Test in past year

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Name of applicant's primary physician:

____ __________________
Name Telephone

____
Address City/State/Zip

Has applicant had dental examination in the past year? ____yes ____no

____ __________________
Name of Dentist Telephone

____
Address City/State/Zip

List any specialist who have treated or are treating the applicant:

____ __________________
Name Telephone

____ __________________
Name Telephone

(Continue on back of page if there are more)

Please list all medications the applicant is taking: (can cont. on back)

Name	Dosage & Frequency	Prescribed by	When prescribed

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ALLERGIES/RESTRICTIONS

1) Is applicant allergic to any medications? If yes, please list and explain____________

2) Is applicant allergic to foods, pollens, insect bites, skin contacts, substances, etc? If yes, please describe reaction and treatment necessary:______________________________

3) Does applicant have any dietary restrictions? If yes, please explain________________

4) If applicant is on any medication/injection for allergies, please give name of medication/injection, dosage and frequency:

Prescribed by____

FAMILY HISTORY

Since some conditions can be hereditary, or run in families, please provide the following information: If any member of the applicant's family has had any of the following conditions or problems, please indicate and identify their relationship to the applicant.

Hypertension_________________________ Stroke__________________________

Heart Attack__________________________ Kidney Disease__________________

Diabetes______________________________ Gout____________________________

Cancer_______________________________ Arthritis_________________________

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Migraines_____________________________ Glaucoma______________________

Epilepsy______________________________ Other__________________________

APPLICANT'S HEALTH HISTORY:

If the applicant is prone to (or has had) problems with any of the following, please indicate Yes or No. If Yes, explain in space provided. Also, list preferred treatment, if applicable. If more space is needed, use the back of this page.

Cold/Sinus trouble __Y __N ____

Headaches __Y __N ____

Eyes __Y __N ____

Glasses (attach RX) __Y __N ____

Ears __Y __N ____

Hearing __Y __N ____

Chest infections __Y __N ____

Asthma __Y __N ____

Epilepsy __Y __N ____

Pneumonia __Y __N ____

Tuberculosis __Y __N ____

Heart Trouble __Y __N ____

Kidney Disease __Y __N ____

Stomach Trouble __Y __N ____

Diabetes __Y __N ____

Diarrhea/Constipation __Y __N ____

Fainting Spells __Y __N ____

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HIV/AIDS __Y __N ____

Menstrual Problems __Y __N ____

Muscle Problems __Y __N ____

Neurological Problems__Y __N ____

Emotional Problems __Y __N ____

Psychological Problems__Y __N ____

Psychiatric Problems __Y __N ____

HISTORY OF ILLNESS/HOSPITALIZATION/SURGERY

Please list childhood diseases (mumps, chickenpox, etc)____________________________

____

____

Has applicant had a lengthy illness within the past three years? __yes __no
If yes, list the date and explain the illness____

____

____

Attending physician and telephone:____

Has applicant ever been hospitalized? ___yes ___no. If yes, when_______________

Hospital/Address ____

Reason____

Has applicant had surgery? __yes __no. If yes, when___________________________

Description: (use back for additional hospitilizations)___________________________

____

Physician & Telephone____

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If there is any further information you feel should be provided which is a factor and could influence the care, health, and well-being of the applicant at Glory Community, please explain:

____

The information in the above medical history is correct to the best of my knowledge.

____ _____________________
Signature of Parent/Guardian Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE ANYONE WHO HAS ANY INFORMATION REGARDING:

____

(Applicant)

TO RELEASE SAID INFORMATION THEY HOLD ON HIM/HER TO GLORY COMMUNITY.

____ __________________

Parent/Guardian Signature Date

COPIES OF THIS RELEASE MAY BE USED TO OBTAIN INFORMATION FROM ANYONE LISTED ON (Applicant's Name)____________________________________ APPLICATION FOR ACCEPTANCE INTO GLORY COMMUNITY.

____ __________________

Parent/Guardian Signature Date