P.O. Box 107
Gainesville, Georgia 30503
Phone: 770-535-1000
Email: mmgc13@gmail.com
www.ourneighbor.org

APPLICATION FOR RESIDENCE

PERSONAL

Name: _____
First Middle Last

Present Address: _____
City State Zip

The above address is: Personal Residence _____ Parents' Home _____ Hospital _____
Rehabilitation Facility _____ Nursing Home _____ Other _____

Home Phone No. _____Work Phone No. _____Cell Phone No._____

Date of Birth: _____ U.S. Citizen? _____ If no, have you been naturalized?_____

When? _____ Language(s) you speak: _____

Have you served in the military? _____If yes, which Branch and dates served:
_____
_____

Height: _____ Weight: _____ Social Security No. _____

Do you have a guardian? _____ Conservator? _____ Power of Attorney? _____
Living Will?_____

If yes, name and address of the designee:
_____

_____

_____

Email address:_____

FAMILY

Marital Status

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Name of Spouse: _____

Address: _____

Living with you? _____ Spouse's Occupation/Employer _____

Children

Name	Address	Age	Living with you?

Father

Name: _____ Phone No. (W) _____ (H) _____

Address _____

Age, if living or when deceased _____ Served in the military? _____ Health Status?_____

Mother

Name: _____ Phone No. (W) _____ (H) _____

Address _____

Age, if living or when deceased _____ Served in the military? _____ Health Status?_____

Siblings

Name	Address	Age	Living with you?

Other Primary Persons to contact in case of emergency:

Name: _____ Phone No. _____
Addresss:
_____
_____

EDUCATION

What is the highest level of education you have completed? _____

Please list schools attended beginning with the most recent:

Schools Attended:

From (Dates) To	Name	Address	Degree

Have you ever received vocational training? _____ if yes, please complete:

Vocational Training:

From (Dates) To	What Kind	Counselor _____

What might be your future educational goals if you move into an OUR NEIGHBOR, INC. home?

_____

_____

SOCIAL

Describe your typical day: _____

_____

_____

_____

List all community or state agencies from which you are receiving or have received assistance:

Name of Agency Address of Agency Contact Person/Counselor

_____

_____

_____

Do you have a pet or service animal? _____ Describe: _____

Do you have a current driver's license? _____ If so, what state? _____
DL#_____Exp. Date:_____

Each person living in an ONI residence will be expected to share in collective planning and decision-making for the residence and contribute as much as he or she is able to the daily tasks of the same. What skills, talents, or gifts might you be able to share with the ONI residents?

_____

_____

_____

Do you have any hobbies or special interests?_____

_____

Why would you like to live in an ONI residence?_____

_____

Any other information you feel would be relevant to joining the ONI Residential Program?

_____

_____

_____

MEDICAL INFORMATION

Insurance:

Medicare Number: _____ Do you have Medicaid? _____
(if applicable)

Medicaid No. _____

Which insurance provider do you have? (i.e. BlueCare, Access Med Plus) _____

_____

Other insurance coverage (i.e. accident, cancer, workman's comp, etc.) _____

Name of insurance company: _____

ID/Plan Number_____

Group number: _____

How are your insurance premiums paid? _____

- In addition to Medicare/Medicaid benefits, residents are responsible for maintaining whatever private healthcare insurance is needed or desirable. OUR NEIGHBOR, INC. is not responsible for any health related expenses incurred by the resident including, but not limited to, dental care, care of eyes, hearing aids, eye glasses, prostheses, orthopedic appliances, or diagnostic studies or treatment of physical or mental conditions.

REQUEST FOR MEDICAL/MENTAL HEALTH INFORMATION

In order to process your application we must receive information from three medical sources (including Psychiatric Evaluations). Please list the complete names, address, and phone numbers below.

	Doctor's Name	**Address**	**Phone Number**
1.			
2.			
3.			

Accompanying this form are three copies of the Request for Medical/Mental Health Information forms. Please fill out all three forms so that we can request your medical records.

MEDICAL

Primary diagnosis or disability: _____ICD-10 code: _____

Age of onset: _____ Congenital? _____ Traumatic/Accidental? _____

If traumatic/accidental, please describe circumstances: _____

_____

If spinal lesion, lesion level: _____ Complete: _____ Incomplete: _____

All other diagnoses (supply ICD-10 codes):

_____

_____

_____

Primary Care Physician: _____ Practice Name:_____

Address: _____ Phone: _____

TREATMENT HISTORY

Please list hospitals, rehabilitation centers, nursing homes, or other residential placements from which you have received treatment or care during the last five years.

From Dates (To) Name & Address of Facility Reason for Admission

_____

_____

_____

_____

Do you receive any Occupational or Physical Therapy or skilled Nursing Care?

_____

Please list names of therapists, contact information, type of therapy (Nursing, Occupational therapy, speech/language, vision or physical therapy) and frequency of visits in last two years

Therapy Type Name & Address of Facility Frequency of therapy

_____

Do you have visual impairment? _____ Describe: _____ Glasses? _____

Diagnosis & ICD-10 Code: _____

Do you have hearing impairment? _____ Describe: _____ Hearing Aid? ____

Diagnosis & ICD-10 Code: _____

Who is currently providing your primary care and assistance? Name: _____

Mobility:
Do you use an electric wheelchair? _____ Manual wheelchair? _____ Walker? _____

Communication:
Do you have speech impairment? _____ Describe: _____

Diagnosis & ICD-10 Code _____

Do you have a communication device? _____ Word board? _____

Are you able to read? _____ Write? _____

Are there any other issues/concerns regarding your medical and/or physical condition which you specifically wish to share in order for Our Neighbor, Inc. staff to better understand your individual needs and situation?

*Our Neighbor, Inc. is not responsible for providing medical or mental health treatment including dental or eye care; however, assistance will be given in making appointments and transporting residents to appointments if necessary.

ACTIVITIES OF DAILY LIVING

Please check the appropriate level of care you require for each of the following activities:

	No Assistance	Partial Assistance	Total Assistance
Walk/use wheelchair	_____	_____	_____
Get in/out of car/bus	_____	_____	_____
Eating/Utensil use	_____	_____	_____
Open/close door	_____	_____	_____
Lock/unlock door	_____	_____	_____
Operate light switches	_____	_____	_____
Open/close curtains, windows	_____	_____	_____
Adjust the heating/air conditioning	_____	_____	_____
Mobility	_____	_____	_____
Sit down/get up from toilet	_____	_____	_____
Reach and use toilet paper	_____	_____	_____
Flush the toilet	_____	_____	_____
Clean the toilet	_____	_____	_____
Walk up/down stairs	_____	_____	_____
Use the elevator	_____	_____	_____
Get in/out of bed	_____	_____	_____
Dressing	_____	_____	_____
Take shoes off/put on	_____	_____	_____
Make bed, change sheets	_____	_____	_____
Turn faucets on/off	_____	_____	_____
Wash hands and face	_____	_____	_____
Wash body (in basin)	_____	_____	_____
Wash hair (in basin)	_____	_____	_____

	No Assistance	Partial Assistance	Total Assistance
Move on/off chair	_____	_____	_____
Peel, grate, cut food items	_____	_____	_____
Open containers, cans, jars	_____	_____	_____
Wash/dry dishes	_____	_____	_____
Wash/wipe countertops & tables	_____	_____	_____
Purchase/put away groceries	_____	_____	_____
Dispose of garbage bags	_____	_____	_____
Do hand washing	_____	_____	_____
Carry laundry bag or basket	_____	_____	_____
Load/empty washing machine/dryer	_____	_____	_____
Operate washing machine/dryer	_____	_____	_____
Iron clothes	_____	_____	_____
Dust furniture	_____	_____	_____
Use vacuum cleaner	_____	_____	_____
Sweep with broom	_____	_____	_____
Wipe/mop the floor	_____	_____	_____
Wash windows	_____	_____	_____
Weed/plant flowers	_____	_____	_____
Answer the telephone	_____	_____	_____
Dial a number	_____	_____	_____
Use computer	_____	_____	_____
Comb hair	_____	_____	_____
Brush teeth/use toothpaste	_____	_____	_____
Shave using razor/electric razor	_____	_____	_____
Get in/out of shower	_____	_____	_____

	No Assistance	Partial Assistance	Total Assistance
Get in/out of bathtub	_____	_____	_____
Wash and rinse body and hair	_____	_____	_____
Reach towel	_____	_____	_____
Clean bathtub/shower	_____	_____	_____
Use Enemas (n/a _____)	_____	_____	_____
Use catherizations (n/a _____)	_____	_____	_____
Use irrigations (n/a _____)	_____	_____	_____
Use suppositories (n/a _____)	_____	_____	_____
Take medications	_____	_____	_____
Use small kitchen appliances	_____	_____	_____
Turn on/off stove, fan, oven, & dishwasher	_____	_____	_____
Take food in/out of oven	_____	_____	_____
Take food in/out of refrigerator	_____	_____	_____
Open/close door on cupboards	_____	_____	_____
Open/close drawers in kitchen	_____	_____	_____
Take dishes, pots, pans, food in/out of cabinet	_____	_____	_____

FINANCES

Monthly Income: _____ (total)

Sources of monthly income:	Amount
Wages	
Social Security (Who is the Payee?)	
Supplemental Security Income (SSI)	
Disability (List Source)	
Pension (List Source)	
V.A. or R.R	
Interest/Dividends (List Source)	
Trust Fund	
Help from relatives, friends, church (List Source)	
Other	

Can you meet the monthly fee for room, board, utilities, transportation, & care of $1,200 per month? ____

If not, how much can you pay per month? _____

- ❖ Persons unable to meet the full monthly fee may be assisted within the limits of available resources.
- ❖ What is your anticipated intake/move date? _____

REFERENCES

Please list five personal references that we may contact

Name	**Complete Address**	**Phone Number**
1.		
2.		
3.		
4.		
5.		

AUTHORIZATION

I understand that intentionally misrepresenting any information on this application may disqualify me from entrance into the ONI program and I hereby authorize Our Neighbor, Inc. to verify any information herein.

_____ _____

Signature/ Mark of Applicant Date

Application completed by (If different than applicant):

_____ _____

Name Relationship to Applicant

_____ _____

Signature/ Mark of Applicant Phone Number

Please SIGN the attached HIPPA Privacy Act Form

Please SIGN the attached Liability Waiver

Please sign the attached Resident's Contract

Please Provide a Copy of your Medicare/Medicaid Card

Please Provide a Copy of any private Insurance Cards (if applicable)

Please Provide Copies of three months of all Income sources.

OUR NEIGHBOR
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, (name of patient) _____, authorize (name of person or entity to make or use (disclosure) _____to use and/or disclose the protected health information as identified below to (name of recipient) _____.

Please give a specific and meaningful description of the protected health information to be us be used or disclosed: _____
_____
_____

My protected health information is being used or disclosed for the following purposes: (description of the purpose of the authorization- "At the request of the individual" is acceptable if the patient initiates the request and does not want to state a specific purpose) _____
_____
_____

This authorization shall be in force and effect until (give expiration date or an expiration event) _____at which time this authorization to use or disclose my protected health information expires.

I understand that I may revoke this authorization at any time by giving written notice. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed by the recipient may no longer be protected by federal law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print name of legal representative (if applicable) Relationship to Patient

OUR NEIGHBOR
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, (name of patient) _____, authorize (name of person or entity to make or use (disclosure) _____to use and/or disclose the protected health information as identified below to (name of recipient) _____.

Please give a specific and meaningful description of the protected health information to be us be used or disclosed: _____
_____
_____

My protected health information is being used or disclosed for the following purposes: (description of the purpose of the authorization- "At the request of the individual" is acceptable if the patient initiates the request and does not want to state a specific purpose) _____
_____
_____

This authorization shall be in force and effect until (give expiration date or an expiration event) _____at which time this authorization to use or disclose my protected health information expires.

I understand that I may revoke this authorization at any time by giving written notice. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed by the recipient may no longer be protected by federal law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print name of legal representative (if applicable) Relationship to Patient

OUR NEIGHBOR
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, (name of patient) _____, authorize (name of person or entity to make or use (disclosure) _____to use and/or disclose the protected health information as identified below to (name of recipient) _____.

Please give a specific and meaningful description of the protected health information to be us be used or disclosed: _____
_____
_____

My protected health information is being used or disclosed for the following purposes: (description of the purpose of the authorization- "At the request of the individual" is acceptable if the patient initiates the request and does not want to state a specific purpose) _____
_____
_____

This authorization shall be in force and effect until (give expiration date or an expiration event) _____at which time this authorization to use or disclose my protected health information expires.

I understand that I may revoke this authorization at any time by giving written notice. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed by the recipient may no longer be protected by federal law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print name of legal representative (if applicable) Relationship to Patient