Application for Services

We appreciate that you want to know more about Langton Green, and we welcome your application. The questions in this packet will be used to:

- Help in the selection of applicants, and
- Establish the background information that will enable program staff to know each applicant better.

You are probably wondering about fees:

- The program fee is determined by a standardized formula via the Maryland Department of Disabilities Administration (DDA) regulations.
- Rent is determined by a sliding scale using a formula provided by the Department of Housing and Urban Development (HUD) for Section 8 housing projects. No applicant will be denied admission because of race, color, religion, national origin, or sex.

All information you submit will remain confidential. You may return the completed application to:

Langton Green, Inc.
Attention: Residential Application
3016 Arundel on the Bay Road
Annapolis, MD 21403
Fax: 410-269-0297
info@langtongreen.org
Applicant Name ________________________________

Date: ____________________

Applicant:_________________________________________________________________________

Last              First    Middle

Present living arrangements: ________________________________________________________

________________________________________________________________________________

Address: __________________________________________________________________________

_________________________________________________________________________________

City                  State            Zip Code                    County

Phone: _________________________________

Social Security Number: _____ - _____ - _____       Gender: M ____    F ____

Date of Birth: _____ / _____ / ______      Place of Birth: _______________________________

Race: ___________________________      Marital Status: _________________________________

Referring agency: __________________________________________________________________

Referring agency representative: ___________________________________________________

Referring agency phone: ___________________________

If not an agency referral:

    Name of individual referring: ___________________________________________________

    Relationship to applicant: ______________________________________________________

    Phone number: ______________________________

Emergency Information

Name of #1 emergency contact: _______________________________________________________

Phone: _______________________     Relationship: _____________________________________

Name of #2 emergency contact: _______________________________________________________

Phone: ______________________     Relationship: _______________________________________

________________________________________
Applicant Name ___________________________________ 2

Vocational / Educational

Is applicant employed? Yes _____ No _____

If yes, where? ______________________________________________________________________

Contact person: ____________________________ Phone: ____________________________

If no, what program does the applicant attend? ______________________________________________________________________

Contact person: ____________________________ Phone: ____________________________

Address: ___________________________________________________________________________

Date began attending: _____________________________

Skill Development and Independent Functioning

Please indicate whether the applicant requires assistance or functions independently in
the following areas. Feel free to elaborate on any item on the back of this page.

<table>
<thead>
<tr>
<th>Needs Assistance</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td></td>
</tr>
<tr>
<td>Bathroom</td>
<td></td>
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<tr>
<td>Bathing</td>
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<tr>
<td>Shampooing</td>
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<tr>
<td>Brushing/combing hair</td>
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<td>Brushing teeth</td>
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<td>Shaving</td>
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<td>Dressing</td>
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<td>Use of telephone</td>
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<td>Use of money</td>
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<tr>
<td>Use of public transportation</td>
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<tr>
<td>Making purchases</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
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</tbody>
</table>

Does the applicant perform any household or other chores on a regular basis? If so, describe: ______________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

How does the applicant spend leisure time; for example: activities, interests, hobbies, etc.? ______________________________________________________________________

____________________________________________________________________________________

LG1 5/13/19
Applicant Name ___________________________________

Why are you applying to Langton Green? ___________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What do you expect the applicant to gain from the program? _______________________
_____________________________________________________________________________________
_____________________________________________________________________________________

How did you find out about Langton Green? ________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Family History

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
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<td>Address:</td>
<td>Address:</td>
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<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Age:</td>
<td>Age:</td>
</tr>
<tr>
<td>Marital status:</td>
<td>Marital status:</td>
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<tr>
<td>Work phone:</td>
<td>Work phone:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Siblings</th>
<th>Siblings</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>Age</td>
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<tr>
<td>Name</td>
<td>Age</td>
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</tbody>
</table>

Background Information

Is there a history of disability in the family? If yes, please explain what the disability is, and who in the family is disabled: _____________________________________________
___________________________________________________________________________
___________________________________________________________________________

Complications of pregnancy/delivery: _________________________________________
___________________________________________________________________________

First notice of disability: _________________________________________________
___________________________________________________________________________

LGI 5/13/19
Developmental milestones (sat up, walking, talking, etc.): ____________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Educational history – schools and dates attended: ________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Vocational history – programs attended and dates: ________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Behavioral and Emotional Background**

Please describe the applicant’s behavior (appropriate vs. childish): ________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Are there any specific behavioral problems? ________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Is the applicant emotionally prepared to move into an alternative living situation?
_____________________________________________________________________________________
_____________________________________________________________________________________

What should we know about the applicant to best serve him/her? ________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Medical Background Information**

Please provide name, address, and phone for the following physicians:

<table>
<thead>
<tr>
<th>Primary name:</th>
<th>Address:</th>
<th>Phone:</th>
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</thead>
<tbody>
<tr>
<td>Psychiatrist name:</td>
<td>Address:</td>
<td>Phone:</td>
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<tr>
<td>Dentist name:</td>
<td>Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Ophthalmologist name:</td>
<td>Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Other name and Specialty:</td>
<td>Address:</td>
<td>Phone:</td>
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</tbody>
</table>
Medications, including over-the-counter and vitamins (use back if necessary):

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Reason given</th>
<th>Prescribed by</th>
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</table>

Pharmacy name: ___________________________________________________________________

Address: _________________________________________________________________________

________________________________________________    Phone: _________________________

**Medical History**

List childhood illnesses:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
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_________________________________________________________________________________
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_________________________________________________________________________________

List hospitalizations and/or surgeries, along with date and reason:

_________________________________________________________________________________
_________________________________________________________________________________
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Does the applicant have any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech:</td>
<td></td>
<td></td>
<td>Hearing:</td>
<td></td>
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<tr>
<td>If no, how does the applicant communicate?</td>
<td></td>
<td></td>
<td>Uses hearing aids:</td>
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<td></td>
<td>Yes</td>
<td>No</td>
<td>Deaf:</td>
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<td>Right</td>
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<td>Left</td>
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<tr>
<td>Cardiac:</td>
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<td>Blindness:</td>
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<td>Orthopedic:</td>
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<td>Wears glasses:</td>
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<td>Amputation:</td>
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<td>Diabetes:</td>
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<tr>
<td>Epilepsy:</td>
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<td>Takes insulin:</td>
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<td></td>
<td>Yes</td>
<td>No</td>
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<td>If yes, frequency:</td>
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<td>Severity:</td>
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<td>What’s typical?</td>
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</tbody>
</table>

Other (please specify):

Allergies
- Food:
- Medication:
- Environmental:
- Seasonal:
- Typical reaction:
- What treatment is needed for a reaction?

Nutrition
- Is there a special diet or restrictions?

- Likes:
- Dislikes:
- Anything the applicant CANNOT eat:

Medical Appointments
- Behavior on appointments:
- Requires sedation for any appointments or procedures:

Is there anything else the nurse should know?

Person who assisted in filling out this application: ________________________________

Signature: ________________________________ Date: ____________________

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