Group Living, Inc.
PO BOX 159
700 Main St STE 200
Arkadelphia, AR 71923
870-246-5849

Services Include:
Medicaid Waiver Services
Community Employment
Beehive Resale Store
Day Service Programs

Application for Services

(Applicant Information)

Name: (*Last*)________________________ (*First*)_________________________ (*Middle*)________________
Nickname:__________________________ Sex: ___ Male ___ Female
Date of Birth: _____/______/________________ Medicaid #________________________________
Social Security Number: _____-______-____________ Medicare #________________________________
SNAP/EBT#_____________________________________ Third Party Ins. #__________________________
ID/Driver License #: _____________________________ State of Issuance: _________________________
Mailing Address: Physical Address:
____ ____
____ ____
Telephone: Home (____) ________________________ Mobile (____) _________________________
Other (____) ________________________ Other (____) _________________________
Do you send or receive text messages? ___ Yes ___ No ***Preference***: ________ Call _________ Text
Primary Language Spoken: ______________________ Secondary Language Spoken:________________
Race: ___Caucasian ___ African American ___ Native American __ Asian ___ Hispanic
___Other (*Please specify*) ____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Any Children: ___ Yes ___ No If yes, how many existing children? __________________

(Guardian/Parent Information)

Guardianship Status: ___ Own Guardian ___ Father/Mother ___ Other (*Please specify*)_________________
Name of Parent/Guardian(s): ____
Mailing Address: Physical Address:
____ ____
____ ____
Telephone: Home (____) ________________________ Mobile (____) _________________________
Other (____) ________________________ Other (____) _________________________
Do you send or receive text messages? ___ Yes ___ No ***Preference***: ________ Call _________ Text

Primary Contact: _______________________________ Phone #: _________________________________
Mailing Address: Physical Address:
____ ____
____ ____
Do you send or receive text messages? ___ Yes ___ No ***Preference***: ________ Call _________ Text
Secondary Contact: _______________________________ Phone #: _________________________________
Mailing Address: Physical Address:
____ ____
____ ____
Do you send or receive text messages? ___ Yes ___ No ***Preference***: ________ Call _________ Text

***Please refer to Page 5 to list more contact references.**

Please indicate the following diagnosis:

Intellectual Developmental Disability (IDD) ________ Epilepsy________ Cerebral Palsy ______

Autism Spectrum Disorder_____ Other (*Please Specify*) ____________________________________

Indicate which service(s) you are applying for at Group Living Inc.:

Adult Day Services ______ Medicaid Waiver Services ______ Community Employment______

Indicate previous and current service(s) being received:

______Nursing Home ______ Adult Day Services ______ Special Education

______ ARS ______ ACTI ______ Group Home

______ Other (Please Specify) ____

Please indicate location of following services: ____

____

Has the applicant applied for Medicaid Waiver Services? ___ Yes ___ No

If yes, provide waiting list number and the year applied: Number: _________ Year: ________

Medical Information

Primary Care Physician (PCP):

Name: ______________________________________ Telephone: ______________________________

Address: ____

Dentist:

Name: ______________________________________ Telephone: ______________________________

Address: ____

Optometrist:

Name: ______________________________________ Telephone: ______________________________

Address: ____

Speech Therapist:

Name: ______________________________________ Telephone: ______________________________

Address: ____

Physical Therapist:

Name: ______________________________________ Telephone: ______________________________

Address: ____

Psychologist:

Name: ______________________________________ Telephone: ______________________________

Address: ____

Psychiatrist/ Counselor:

Name: ______________________________________ Telephone: ______________________________

Address: ____

Other Specialist:

Name: ______________________________________ Telephone: ______________________________

Address: ____

Medical Information Cont.

Please list all current medication(s) being taken:

Name/ Dosage/ Frequency – What for?

____
____
____
____
____
____

Name/ Dosage/ Frequency – What for?

____
____
____
____
____
____

Allergies:

____
____
____
____
____
____

Dietary Needs:

____
____
____
____
____
____

Is applicant being treated for a current medical condition? ___ Yes ___ No

If yes, specify ____

Applicants Overall General Health: ___ Good ___ Fair ___Poor

Wheelchair Information/Service: ____

Primary Diagnosis: ____

Secondary Diagnosis: ____

Limitations or Necessary Precautions to be taken:

____
____
____
____

Other Diagnosis:

____
____
____
____

____
____
____
____

Medical History

List past surgeries/procedures with the year they were performed:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

List Previously Taken Prescriptions:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Comments or other important information, provide below:

____
____
____

Financial Information

Does the applicant receive Social Security (SS) Benefits or Supplemental Security Income (SSI)?
___ Yes ___ No

Amount received monthly: $___________________

If the applicant does not receive SS or SSI, what income does he/she have?

____

Does the applicant have a checking and/or savings account? ___ Yes ___ No

Please provide where: ____
____

Does the applicant have any outstanding financial obligations? ___ Yes ___ No

If yes, please provide explanation:

____
____
____
____

Personal & Family Descriptions

Please provide a brief description of the applicant that include physical description, personality characteristics, identified or problematic behavior, abilities, strengths, weaknesses, and relationship with his/her family members and friends. If you identify a problematic behavior, please be descriptive. We will need to monitor and incorporate skills to help him/her overcome them.

____
____
____
____
____
____

Please provide a brief description of the applicant's family. Include name, age and birth dates of immediate family members.

____
____
____
____

Please list by **importance** emergency contacts for the applicant. Provide name, relationship, phone number, and address:

1. Name: _________________________ Relationship: ______________ Phone #: (___)_____________
   Address:____
2. Name: _________________________ Relationship: ______________ Phone #: (___)_____________
   Address:____
3. Name: _________________________ Relationship: ______________ Phone #: (___)_____________
   Address:____
4. Name: _________________________ Relationship: ______________ Phone #: (___)_____________
   Address:____

Has any other family member applied for services at Group Living, Inc.? ___ Yes ___ No

If yes, please identify the individual and provide a brief explanation along with a date:

____
____
____

Are all family members allowed to have contact with the applicant? ___ Yes ___ No

If no, please list name and relationship below:

1. Name:______________________________ Relationship: ______________________________
2. Name:______________________________ Relationship: ______________________________
3. Name:______________________________ Relationship: ______________________________

Instructive/Occupational Information

Provide a brief report of education and occupational training the applicant may have received or is currently receiving. Include location, dates, and specifics of the training. If the applicant attended public school, list the school name and last grade attended. *Please attach diploma or certificate of highest education completed if applicable*.

____
____
____
____

Name of Public School: ____________________________Highest Grade of Completion: _________

Location: ____

Has the applicant been affiliated with another program? ___ Yes ___ No

If yes, please provide the name of the program and the reason for leaving.

____
____

Has the applicant been employed? ___ Yes ___ No

If yes, please provide location, period (date), type of work, salary, and reason for leaving or indicate if he/she is currently working.

____
____
____
____

Please provide all the applicant's skills that could be helpful in his/her job training. Examples are but are not limited to: machine operation, laundry skills, art, woodwork, sewing, janitorial skills, use of office equipment, administrative or social skills, money association skills, and etc.

____
____
____
____

Requested Documentation

Upon completion of the application, attach the following documents:

1. Birth Certificate ☐
2. Social Security Card ☐
3. Medicaid Card ☐
4. Medicare Card ☐
5. Third Party Insurance (if applicable) ☐
6. Unexpired and Current ID/Driver's License Card ☐
7. Proof of Guardianship (Court Order) ☐
8. Psychological Evaluation – assessed before the age of 22. ☐

Print Name of Individual Completing Application: ____

Signature: ____ Date: ___/___/____________

Relationship to Applicant: _________________________________

NONDISCRIMINATION NOTICE

GROUP LIVING, INC. clearly complies with all civil rights provisions of federal statues and related authorities that prohibit discrimination in programs and activities receiving federal financial assistance.

1. GROUP LIVING, INC. does not discriminate on the basis of race, sex, color, age, national origin, religion or disability in the admission, access to and treatment in the programs and activities, as well as the hiring or employment practices.
2. Complaints of alleged discrimination and inquiries regarding GROUP LIVING's nondiscrimination policies may be directed to
   Yukiko Taylor (Title VI and ADA/504 Coordinator)
   Executive Director
   Group Living, PO Box 159, Arkadelphia, AR 71923
   Email Address: ytaylor@groupliving.org
   870-246-5849 (office)/TTY 711 or 800-285-1131
3. This notice is available on audiotape and braille upon request.
4. This notice is available from the Executive Director in large print if requested.

Free language assistance for Limited English Proficient individuals is available upon request

---

Internal Use Only: Accepted:_______
Date of Application:____/____/_______ Denied: _______
Signature: ________________________ Date of Approval/Denial: ___/___/______