New Member Information

DATE: ____/____/____

Academy at Glengary, 1910 Glengary Street, Sarasota, FL 34231 Tel: 941-921-9930

☐ male

Name: _____ ☐ female
(first) (middle) (last)

Date of Birth _____/_____/_____ Place of Birth _____ SSN# _____-_____-_____

Address _____ _____
(street) (apartment)

_____ _____ _____ _____
(city) (state) (zip code) (phone number)

Mailing Address *(if different from above)* _____
(street) (apartment)

_____ _____ _____ _____

Next of Kin: _____ Relationship: _____

Address _____ _____
(street) (apartment)

_____ _____ _____ _____
(city) (state) (zip code) (phone number)

Marital Status: ☐never married ☐married ☐widowed ☐divorced ☐separated ☐permanent partner

Race: ☐African-American ☐American Indian ☐Asian ☐Caucasian ☐Multi-Racial ☐Pacific Islander ☐Other

Ethnicity: ☐Cuban ☐Mexican ☐Puerto Rican ☐Hispanic ☐Non-Hispanic ☐Haitian ☐Other

EDUCATION

(mark highest completed)

☐ 1st grade ☐ 2nd grade ☐ 3rd grade ☐ 4th grade ☐ 5th grade ☐ 6th grade ☐ 7th grade
☐ 8th grade ☐ 9th grade ☐ 10th grade ☐ 11th grade ☐ 12th grade ☐ GED ☐ 1 yr. college
☐ 2 yrs. college ☐ 3 yrs. college ☐ BA or BS ☐ some graduate school ☐ graduate degree

Veteran Status: ☐Veteran ☐Spouse of Veteran ☐Non-Veteran Service Connected Disability: ☐ Yes ☐ No
Honorable Discharge: ☐ Yes ☐ No Non- Service Connected Disability: ☐ Yes ☐ No
If yes, did you serve over two years? ☐ Yes ☐ No

REFERRAL SOURCE (How did you hear about Vincent Academy?)

Name: _____ Relationship: _____

Organization: _____
(name) (address)

_____ _____
(city) (state) (zip code) (phone number)

HOUSING STATUS (check all that apply)

☐ Alone ☐ ALF ☐ Group Home ☐ Adult Foster Care
☐ Hospital ☐ Homeless ☐ Supported Housing ☐ Nursing Home
☐ Share housing with relatives: Cost share: ☐ Yes ☐ No
☐ Share housing with non-relatives: Cost share: ☐ Yes ☐ No

How many people live in your household? _____ Are you a single parent? ☐ Yes ☐ No

In total, number of children under 18 in your household? ____ If yes, number of children? ___

List the people in your household:
☐ spouse ☐ father ☐ mother ☐ son(s) ____ ☐ daughter(s)____
☐ grandmother ☐ grandfather ☐ other relative(s)___ ☐ friend(s) ____

TRANSPORTATION

How will you arrive to the Academy? ☐ public transportation ☐ by taxi ☐ walk / bicycle ☐ drive own car
Do you have a Driver's License? ☐ Yes ☐ No

EMPLOYMENT

Current Employment: ☐ part-time ☐ full-time ☐ unemployed
Future Goals: ☐ maintain current job ☐ obtain part-time job ☐ obtain full-time job ☐ not seeking paid work

If currently employed:

Employer:_____ Employer Address _____

Employer Phone _____ Type: ☐clerical ☐management ☐professional ☐retail ☐sales

If you are not currently employed, what do you do during the day? _____

WORK HISTORY:

Dates	Employer	Job Title - Type of Work	Hours/week	Pay/hour

Estimate number of paid jobs you have had: _____ Estimate number of years you have worked for pay: _____

Are you involved with VR (Vocational Rehabilitation)? ☐ Yes ☐ No If yes, Counselor is_____

Are you enrolled in Supported Employment? ☐ Yes ☐ No If yes, agency is_____

INCOME (check all that apply and enter monthly amounts)

☐ children $_____ ☐ child support $_____ ☐ family support $_____ ☐ friend support $_____
☐ parents $_____ ☐ OSS $_____ ☐ public assistance $_____ ☐ veteran's benefits $_____
☐ retirement $_____ ☐ social security $_____ ☐ spouse $ _____ ☐ SSDI $_____
☐ SSI $_____ ☐ wages $_____ ☐ other $_____

Do you have a REP PAYEE? ☐ Yes ☐ No If yes, Name: _____

Address: _____ Phone: _____

LEGAL HISTORY (Please answer all questions)

Have you ever been arrested? ☐ Yes ☐ No
Have you ever been incarcerated? ☐ Yes ☐ No
Have you ever been convicted of a misdemeanor? ☐ Yes ☐ No
Have you ever been convicted of a felony? ☐ Yes ☐ No
Have you ever physically injured anyone? ☐ Yes ☐ No
If you answered yes to any of these questions, please indicate dates, causes and outcome: _____

_____

_____

Medical (check all that apply)

☐ asthma ☐ chronic pain ☐ diabetes ☐ hypertension ☐ physical impairment ☐ recent surgery
☐ seizure disorder ☐ visual impairment ☐ other _____
Allergies/medical alert_____

Hearing Ability

☐ deaf ☐ hard-of-hearing ☐ deaf and low vision or blind ☐ hard of hearing and low vision or blind
☐ deaf and limited English proficient ☐ hard of hearing and low English proficient

MEDICATIONS:

Medications	Dosage	Time	Medications	Dosage	Time
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

RECENT HOSPITALIZATIONS:

Name of Hospital	Reason for Hospitalization	Admission Date	Discharge Date

Do you have a history of dependency on alcohol or other drugs? ☐ Yes ☐ No

If yes, please indicate substances:_____

Have you ever been in treatment for use of alcohol or other drugs? ☐ Yes ☐ No

Are you currently in treatment or in a support group? ☐ Yes ☐ No

How long have you been “clean and sober”? _____ years _____months

EMERGENCY CONTACTS

Primary contact:

Name: _____ Relationship: _____

_____
(address)

_____ _____
(city) (state) (zip code) (phone number)

Secondary contact:

Name: _____ Relationship: _____

_____
(address)

_____ _____
(city) (state) (zip code) (phone number)

PROVIDER INFORMATION

CASE WORKER/MANAGER:

Name: _____ Agency: _____

Address: _____ _____
(street) (city) (state) (zip code) (phone number)

THERAPIST:

Name: _____ Agency: _____

Address: _____ _____
(street) (city) (state) (zip code) (phone number)

PSYCHIATRIST:

Name: _____ Clinic: _____

Address: _____ _____
(street) (city) (state) (zip code) (phone number)

PRIMARY CARE MD:

Name: _____ Clinic: _____

Address: _____ _____
(street) (city) (state) (zip code) (phone number)

PROSPECTIVE MEMBER

I hereby certify that all information stated on this application is correct.

_____ _____
(signature) (date)