



New Member Information

DATE: ___/___/___

Academy at Glengary, 1910 Glengary Street, Sarasota, FL 34231

Tel: 941-921-9930

Name: _____ male 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)

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

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 the 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)