Mary Bryant Home
A Supportive Living Community for the Blind and Visually Impaired

APPLICATION FOR RESIDENCY

Date: _____

Please read carefully. All questions must be answered. An incomplete application will delay determination for admission. If something does not apply to you, please indicate so with a N/A. Please return the application and all documentation to Mary Bryant Home, 2960 Stanton Street, Springfield, IL 62703.

Applicant Full Legal Name: _____

Co-Applicant Full Legal Name: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____ Marital Status: _____

Home Phone No.: _____ Work/Cell Phone No.: _____

Social Security No.: _____ Co-Applicant's Social Security No.: _____

Medicare No.: _____ Co-Applicant's Medicare No.: _____

Date of Birth: _____ Birth Place: _____
(City County State Country)

Are you a U.S. Citizen? ___ Yes ___ No
If not, are you eligible immigration status? ___ Yes ___ No

Does anyone live with you? ___ Yes ___ No

Does anyone plan to live with you in the future? ___ Yes ___ No
If yes, how many people? ___ Yes ___ No

Do you have a service animal? Type: _____ ___ Yes ___ No

Do you have a Power of Attorney? ___ Yes ___ No

If yes, Name: _____ Phone: _____

Address: _____

Do you have a guardian? ___ Yes ___ No
If yes, Name: _____

Address: _____

Phone: _____

2960 Stanton Street, Springfield, IL 62703
(217) 529-1611 (Phone) (217) 529-6975 (FAX)

Emergency Contact(s):

Name:_____ Name: _____
Address: _____ Address: _____
Phone:_____ Phone: _____
Relationship: _____ Relationship: _____

LANDLORD REFERENCE

Current Landlord:

Name: _____ Phone: _____
Address: _____

How long have you lived at your current address? _____ Years _____ Months
Reason for wanting to move:

_____
_____

Previous Landlord:

Name: _____ Phone: _____
Address: _____

How long did you live at the previous address? _____ Years _____Months
Reason for moving:

_____

CREDIT/CHARACTER HISTORY

Have you ever been evicted? ___ Yes ___ No If so, explain when and circumstances.

_____
_____

Have you ever declared bankruptcy? ___ Yes ___ No If so, explain when and circumstances.

_____
_____

Have you ever defaulted on any financial obligations such as medical bill, student loans, credit cards or household bills? ___ Yes___ No If so, explain when and circumstances.

_____
_____

Have you been convicted of a felony or misdemeanor? ___ Yes ___ No If so, explain when and circumstances.

_____
_____

Have you ever been charged with writing a bad check? ___ Yes ___ No If so, explain when and circumstances.

_____
_____

Have you ever had rent assistance that was terminated for fraud, nonpayment of rent, or failure to re-certify? ___ Yes ___ No If so, explain when and circumstances.

_____
_____

HEALTH HISTORY (Please check all that apply.)

ENDOCRINE/METABOLIC
( ) Diabetes Mellitus[1]
  ( ) Type 1
  ( ) Type 2
( ) Thyroid Disease

HEART/CIRCULATION
( ) Congestive Heart Failure
( ) High Blood Pressure
( ) Other Cardiovascular Disease

MUSKULOSKELETAL
( ) Arthritis
( ) Hip fracture
( ) Other Fractures
( ) Missing Limb
( ) Osteoporosis
( ) Frequent Falls

SENSORY
( ) Cataracts
( ) Glaucoma
( ) Hearing deficit

NEUROLOGICAL
( ) Alzheimer's Disease
( ) Aphasia
( ) Cerebral Palsy
( ) Stroke
( ) Dementia
  (Other than Alzheimer's)
( ) Multiple Sclerosis
( ) Parkinson's Disease
( ) Seizure Disorder[2]
( ) Traumatic Brain Injury

PULMONARY
( ) Asthma
( ) Emphysema/COPD

INFECTIONS
( ) HIV/AIDS
( ) Tuberculosis
( ) Recurrent Pneumonia
( ) Recurrent Urinary Tract
  Infections

PSYCHIATRIC/MOOD[3]
( ) Anxiety Disorder
( ) Depression
( ) Manic Depression (Bipolar)
( ) Schizophrenia
( ) Intellectual Impairment
  (Down's Syndrome, Autism, Developmental disability, Mental Retardation, etc.)
( ) Substance Abuse (alcohol or drug)[4]
( ) Other Psychiatric diagnosis
  (paranoia, phobias, personality disorder, etc.)

OTHER
( ) Cancer _____
( ) Kidney Failure
( ) Special Diet
_____
( ) _____
( ) _____
( ) _____

1. If you checked Diabetes Mellitus, please identify the approximate date of diabetes diagnosis. Date: _____
Explain your current treatment plan including medications, blood glucose testing, and insulin administration if applicable.

_____
_____
_____

2. If you checked Seizure Disorder, please identify the approximate date of diagnosis of seizure disorder.
Date:_____

How frequently do you experience seizure activity? When was your last seizure?

_____
_____

3. If you checked any boxes under Psychiatric/Mood, please provide a date of diagnosis and describe the symptoms you experienced.
Date: _____ Symptoms: _____
_____
_____

4. Please explain your substance abuse history, if applicable. Identify the time frame and any treatment you have completed.

_____
_____
_____

Are you totally blind? ____ Yes ____No

If you have a degree of sight, what is your visual acuity? Right Eye _____ Left Eye _____

Do you have any dietary restrictions or a physician prescribed diet? Please explain.

_____

Please list any allergies to medications, foods, or environmental irritants.

_____

_____

Please list all current medications, including over the counter medications.

_____

_____

_____

_____

_____

_____

Please provide a list of the following:

_____

Primary Care Physician Name Address Phone

_____

Optometrist/Ophthalmologist Name Address Phone

_____

Pharmacy Name Address Phone

_____

Specialist Name and Specialty Address Phone

_____

Specialist Name and Specialty Address Phone

_____

Specialist Name and Specialty Address Phone

APPLICANT CERTIFICATION
PLEASE READ CAREFULLY

I/We understand that the above information is being collected to determine my/our eligibility for housing operated by the Mary Bryant Home Association. I/we authorized the Mary Bryant Home, and/or it's agent(s), to verify all information provided on this application; to contact previous and current landlords; run a criminal record check on all adult members of the household; call personal references, and all other sources for credit and verification information which may be released to appropriate Federal, State and local agencies.

I/we certify that the statements made in this application are true and complete to the best of my/our knowledge and belief. **I/we understand that providing false statements or information is punishable under Federal Law and could result in the denial or rejection of my/our application.**

We only share the information you provide with agencies as needed to assist with your application for admission to our facility.

Signature of Applicant: _____

Date: _____

Signature of Co-Applicant: _____

Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: ____/____/_____

Address: _____ Social Security Number: _____-____-_____

I authorize:

Provider Name: _____

Address: _____

Phone:. _____ Fax: _____

Email: _____

to release any medical, clinical or other information relating to patient named above that may be necessary or convenient for the purpose of application for residency to the:

Mary Bryant Home for the Blind and Visually Impaired.
2960 Stanton Street
Springfield, IL 62703
Phone: (217) 529-1611 Fax: (217) 529-6975

Such information may be exchanged via fax, email (msmith@marybryanthome.org) or mail.

_____ _____
(Signature) (Date)

_____
(Legal relationship to named individual)

_____ _____
(Witness) (Date)

NOTICE TO RECEIVING ORGANIZATION/INDIVIDUAL: *Under provision of the Confidentiality Act, this information shall not be further disclosed unless the person who consented to the disclosure specifically consents to the re-disclosure.*