APPLICATION
MORROW VALLEY FARMSTEAD

GHA Only
Date Application Received:
Initials:

Name *(First, Middle Initial, Last)*	☐ M ☐ F	DOB:
Services Requested:	Placement at Morrow Valley Farmstead _____	
Current address:		

Please provide the information below based on the Applicant's healthcare coverage. Most people will not have all of these.	
Medicaid Number:	County of Medicaid:
Innovations Waiver Recipient? Yes _____ No _____	LME Name:
Medicaid Health Plan (name of Plan/Company):	Health Plan Identification Number:
Private Insurance (Name of Insurance Company):	Identification Number of the Insured:
Medicare Number:	A ____ B _____ D _____
Other Information	
Burial Plan: ☐ Yes ☐ No	Religion (optional):

Legally Responsible Person for Adult Applicant:

☐ Self-Guardian	Name of Guardian/Power of Attorney:
☐ Guardian of the Person	
☐ General Guardian	Relationship of Applicant to Guardian:
☐ Limited Guardian	
☐ Healthcare Power of Attorney	Address:
	Phone number:
	Email address:

HEALTH STATUS

Does the applicant have a diagnosis of Autism Spectrum Disorder?	☐ Yes ☐ No	If yes, age at diagnosis:
Does the applicant have a diagnosis of mental retardation?	☐ Yes ☐ No	If yes, age at diagnosis:
Does the applicant have a diagnosis of a physical disability?	☐ Yes ☐ No	If yes, age at diagnosis:
Does the applicant have a diagnosis of traumatic brain injury?	☐ Yes ☐ No	If yes, age at diagnosis:

Comments:

Current Medical Diagnoses	Is this condition Chronic? (lifelong)		Is this condition terminal? (will result in death)		If the person has a terminal condition, what is the person's life expectancy?
	☐ Yes	☐ No	☐ Yes	☐ No	
	☐ Yes	☐ No	☐ Yes	☐ No	
	☐ Yes	☐ No	☐ Yes	☐ No	
	☐ Yes	☐ No	☐ Yes	☐ No	
	☐ Yes	☐ No	☐ Yes	☐ No	
	☐ Yes	☐ No	☐ Yes	☐ No	
	☐ Yes	☐ No	☐ Yes	☐ No	
Comments					

Primary Care Physician:
Name of Physician:
Address:
Phone Number:

Other Physicians involved in care (such as a Specialist):
Name of Physician: **Specialty:** **Address:** **Phone:**
Name of Physician: **Specialty:** **Address:** **Phone:**
Name of Physician: **Specialty** **Address** **Phone**

[Type text]

Diagnosis of Autism Spectrum Disorder:
Physician or Organization that made the diagnosis:

Current Services		
Name of Provider/Facility:	**Type of Services**	**Date Service Started:**
Does the Applicant have a Plan of Care, Individual Education Plan or other Habilitation Plan? ☐ Yes ☐ No **If yes, please attach.**		
Does the Applicant have a Nursing Care Plan? ☐ Yes ☐ No **If yes, please attach.**		
Does the Applicant have a Behavior Plan or a Crisis Plan? ☐ Yes ☐ No **If yes, please attach.**		
Questions For Applicant, Parent or Guardian:		
What benefits and experiences are you seeking from Morrow Valley Farmstead?		
Do you intend for the applicant to remain at Morrow Valley Homestead for the remainder of his/her life? ☐ Yes ☐ No	**Comments:**	
Other information:		

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Signature of Applicant, Parent/Legal Guardian

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Relationship to Applicant

____
Date

Attachments:

GHA Autism Supports *Health, Family and Behavioral History Form*.

Reminder:

Please provide available documents such as: Psychological, Habilitation Plan, IEP, Nursing Plan, Behavior Plan, Crisis Plan

If attached, please list below:

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