



Independent Living Application

Adult Private Client Application (not used for state agency clients)

Please Mail To:
Independent Living Program/ P.O. Box 50466
Columbia, SC 29250-0466
Phone: 803-681-0150 (call for email address)

Enclosed is our application requesting detailed information about the client. We need this information to help us determine the best possible plan of care for the client.

The following documents are needed on the client prior to admission to the Independent Living Center:

- Medicaid/Private Insurance Card(s) (must provide copy of front and back of card)
- Medical History (to include copies of):
 - most recent medical, vision, and dental check-ups/tests
 - surgeries or hospitalizations
 - list of current prescriptions
- If the client has received mental health services, please provide the following:
Psychological Evaluations and/or Discharge Summaries from:
 - psychiatric/behavioral hospitalization(s)
 - current or (previous) facility/agency placements (reason for placement, length of stay, discharge summary)
Counseling/Therapy Records from:
 - private counselors, mental health, out-patient, etc.
- Birth Certificate copy
- Social Security Card copy
- Immunization Record
- Driver's License (if applicable)
- Copy of GED or diploma

Epworth Children's Home and its services exist for clients as the expression of the desire of the Methodist Church of South Carolina, by providing to the extent of their resources and capabilities, childcare, counseling, and related services to families and clients, without regard to race, religion, national origin, or ability to pay.

Any prospective clients that Epworth is not equipped to serve will be assisted through referrals to other area agencies capable of rendering equivalent or higher-level services.

Please print and complete all sections:

DATE OF APPLICATION: _____ REFERRED BY: _____

CLIENT'S INFORMATION

Name (Last, First, Middle)						
Current Address						
City, State, Zip Code						
Cell Number						
County of Residence						
Social Security Number						
Date of Birth						
Occupation						
Marriage Status (indicate one)	Single	Married	Separated	Divorced		
Race (Indicate one)	Caucasian	African American	Native American	Asian	Hispanic or Latino	Other

INSURANCE INFORMATION

Insurance Company	Policy Holder	Group #	Policy #

EDUCATIONAL INFORMATION

	Effective Date	Describe
High School Graduated From		
G.E.D Received		
Current College Credits (if applicable)		
Future Educational Plans/Goals		

EMPLOYMENT HISTORY

EMPLOYER	DATES

MENTAL HEALTH TREATMENT HISTORY

Agency	City/State	Dates of Service	Diagnosis

DOCTORS

	Name	Phone #	Date of Last Visit
Primary Care			
Dentist			
Specialist(s)			

CHRONIC OR RECURRING ILLNESSES

(Please list below)

HOSPITALIZATIONS/OPERATIONS/SERIOUS INJURIES

Reason	Date

MEDICATION HISTORY

(List current medication including birth control and medication taken within the past 12 months)

Name of Medication	Dosage (i.e., 5mg, 10mg)	Directions (i.e., at bedtime, as needed...)

ALLERGIES

Medication	Food	Seasonal	Other

RESTRICTED ACTIVITIES

(List any restrictions due to a medical condition)

Condition	Restrictions

PLEASE CHECK ALL THAT APPLY TO CLIENT

(Including suspected)

<input type="checkbox"/> Anger/aggression	<input type="checkbox"/> Depression	<input type="checkbox"/> Medically neglected
<input type="checkbox"/> Abusive to animals	<input type="checkbox"/> Emotionally abused	<input type="checkbox"/> Physically abused
<input type="checkbox"/> Abusive to others	<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Physically neglected
<input type="checkbox"/> Abusive to self	<input type="checkbox"/> Oppositional/defiant	<input type="checkbox"/> Sexually abused
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Runaway	<input type="checkbox"/> School issues
<input type="checkbox"/> DJJ/POLICE Involvement/Past and Present Legal Charges (please specify):		
<input type="checkbox"/>		
<input type="checkbox"/> Substance/alcohol use/abuse (please specify):		
<input type="checkbox"/>		

FAMILY HISTORY

(Please Print)

	MOTHER	FATHER
Name		
Address		
City and State		
Phone		
Occupation		
Highest Level of Education		
Level of Involvement		
Marital Status		
Living or Deceased		

RELATIVES INVOLVED

NAME	NUMBER	RELATIONSHIP TO CLIENT

FAMILY ISSUES

(Please indicate all that apply)

	Current	Past	Person(s) Experiencing (i.e.: Self, parent)
Criminal Activity			
Physical Abuse			
Domestic Violence			
Homelessness			
Neglect			
Substance/Alcohol Abuse			
Mental Illness			

SOCIAL SUMMARY

Please explain, in detail why the client is seeking placement at the Independent Living Center:

ROOM AND BOARD SUPPORT AND PAYMENTS

Epworth Children's Home expects the family to fulfill their *ethical* and *legal* responsibility to *pay* to the extent of their ability and resources for the care of their family member placed at Epworth. Epworth Children's Home does not deny the placement of a client due to family's lack of income and financial resources.

PLACEMENT STRATEGIES

Please know that submission of this application *does not guarantee acceptance* to our program. Once the *application* and *all requested information* have been received, it will then be submitted to the Independent Living team for review. Once reviewed, the client will be given a call informing them of the status of the application. At this time, you may be (1.) called in for an interview, (2.) asked to submit additional information, or (3.) given referrals to other area agencies within the state of South Carolina that may be able to provide the level of care the client needs. Should you be accepted for admission to Epworth Children's Home please know that it is on a conditional basis as follows:

Please know that falsifying or withholding any information regarding your current situation and/or history that would help us in determining the best plan of care for you could result, at any time, in the immediate dismissal from our program.

I have read all the above and agree to abide by these provisions.

CLIENT'S SIGNATURE (*Required*)

DATE

CLIENT'S PRINTED NAME (*Required*)

DATE