Noah's Ark of Central Florida

Empowering people who have developmental disabilities to live, laugh and love

Application Checklist

Please ensure you have all the items listed below before submitting your application packet.

__ Completed application (attached)

__ Income verification (social security benefits letter, paystub, or bank statement)

__ Guardianship or Power of Attorney (if applicable)

__ Medical or other evaluation showing the diagnosed disability

__ Resident support form (attached)

__ $50 application fee

__ Mini mental health evaluation completed by one of the counselors on the attached list.

Once this checklist is completed the application will be reviewed and you will be contacted. Approval is not guaranteed and contingent upon a fully complete application package.

If you have questions while gathering this documentation please email Brenda at brenda@noahsarkflorida.org or call 863-687-0804 ext.2105.

Please submit original completed application and supporting documentation to:

Attn: Noah's Ark of Central Florida
500 Inspiration Drive
Lakeland, Fl 33805
863-687-0804

Noah's Ark of Central Florida

Empowering people who have developmental disabilities to live, laugh and love

Noah's Ark of Central Florida is a comfortable, accessible, residential community that provides adults with developmental disabilities access to opportunities that foster independence.

Housing Application

Applicant name: _____

DOB: _____ Gender: ☐Male ☐Female

Current Street Address: _____

City, state, Zip code:_____

Phone Number(s) of Applicant: _____

Marital Status: ☐Single ☐Engaged ☐Married ☐Divorced ☐Widowed

Name of person completing this application: _____

Relationship to applicant: _____

Legal Guardianship or Power of Attorney ☐Yes ☐No (see statement below)

I have consent from the applicant to disclose personal health information and other personal information. (Signature required on last page of application)

Current Living Arrangement (Please Check One):

☐Living in family household with parent/guardian

☐Living in group home

☐Living in assisted living facility

☐Living Independently in an apartment/house in the community

☐Living with roommates in an apartment/house in community

If currently living in a family home, group home or assisted living facility, has the applicant ever lived independently in the community? ☐NO ☐Yes (how long _____)

How did you hear about Noah's Ark?_____

Which of the following best describes your (the applicant's) disability?

☐Autism ☐Cerebral Palsy ☐Developmentally and intellectually disabled

☐Prader-Willi ☐Spina Bifida ☐Emotional Behavior Disability

☐Traumatic Brain Injury ☐Other (Specify) _____

Applicant Financial Status

Is the applicant currently employed? ☐Yes ☐No

If so, where is applicant employed_____?

Estimated monthly income from employment $_____

Would this job continue if the applicant moved to Noah's Ark? ☐Yes ☐No

Please indicate all funding streams the applicant receives and the monthly amounts

SSI (supplemental Security Income) Amount $_____

SSD (Social Security Disability) Amount $_____

VA Benefits Amount $_____

Food assistance program (food stamps) Amount $_____

Special Needs Trust Amount $_____

Parent/guardian financial supplement Amount $_____

Does the applicant currently receive support services through the State of Florida? ☐Yes ☐No

If yes, please indicate source of funding:

☐Medicaid Waiver ☐Consumer Directed Care (CDC) ☐Waitlist

☐Other_____

Does the applicant receive service through Department of Vocational Rehabilitation (VR)?
☐ Yes ☐No

Guardian(s) or Primary Contact Information

Name: _____

Street Address:_____

City, State, zip code:_____

Email: _____ Phone:_____

Name: _____

Street Address:_____

City, State, zip code:_____

Email: _____ Phone:_____

Name: _____

Street Address:_____

City, State, zip code:_____

Email: _____ Phone:_____

Support Service Information

Please check the type of services the applicant currently receives and the agency providing the service:

☐ Personal Supports/ In-Home Supports

☐Supported Employment

☐Supported Living Coaching

☐Residential Habilitation (group home)

☐ Adult Day Training

☐Companion Services

☐Behavior Analysis

☐Transportation Services

☐Home Health Care

Applicant Skills: Daily Living Skills

Please rate the applicant's hygiene tasks

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance	Not Applicable
Showering					
Washing Body well enough to ensure adequate hygiene	☐	☐	☐	☐	☐
Washing hair and rinsing well enough to remove all shampoo/conditioner	☐	☐	☐	☐	☐
Showers Daily	☐	☐	☐	☐	☐
Toileting					
Gets to the restroom in time to prevent accidents	☐	☐	☐	☐	☐
Adequately wipes/cleans self	☐	☐	☐	☐	☐
Uses appropriate amount of toilet paper to prevent toilet clogs	☐	☐	☐	☐	☐
Washes hands after using the restroom	☐	☐	☐	☐	☐
Uses incontinence supplies correctly	☐	☐	☐	☐	☐
Shaving					
Knows what parts of the body to shave	☐	☐	☐	☐	☐
Safely shaves all necessary parts	☐	☐	☐	☐	☐
Dressing					
Chooses weather appropriate clothing	☐	☐	☐	☐	☐
Chooses matching clothing	☐	☐	☐	☐	☐
Puts on clothing correctly	☐	☐	☐	☐	☐

Does the applicant require use of an Epi-Pen or other emergency treatment for allergic reaction?

☐ Yes ☐No

If yes, what allergies _____

Does the applicant of Seizures? ☐Yes ☐No

If yes, what type?_____

How long do the seizures last? _____ Minutes

When was the applicant's last seizure? _____

Who currently schedules the applicant's medical appointments? _____

How does the applicant get to medical appointments? _____

Does the applicant use any sort of adaptive equipment? ☐Yes ☐No

If yes, please check all that apply:

☐Power Wheelchair ☐ Manual Wheelchair

☐Scooter ☐ Walker

☐Cane/Crutches ☐Splints- Type: _____

☐Hearing Aid(s) ☐Glasses/Contacts

☐Communication Device - Type _____

Dietary Needs & Skills

1. Does the applicant eat meals and snacks independently? ☐Yes ☐No
2. Does the applicant require any special dietary requirements? ☐Yes ☐No
   a. If yes, describe: _____

      _____
3. Who is currently responsible for ensuring that the applicant follows dietary requirements?

   _____
4. Are there any mealtime safety concerns for the applicant (Choking, aspiration, stuffing mouth, etc.) ☐ No ☐Yes, _____
5. Does the applicant have an eating disorder (current or past) ☐ Yes ☐No

   If yes, please explain: _____

Please rate applicant's dietary and cooking skills:

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance	Not Applicable
Meal Planning					
Chooses meals to prepare	☐	☐	☐	☐	☐
Makes grocery list according to diet	☐	☐	☐	☐	☐
Goes to store to shop for food	☐	☐	☐	☐	☐
Chooses correct items at store	☐	☐	☐	☐	☐
Food Handling & Storage					
Stores groceries appropriately	☐	☐	☐	☐	☐
Thaws food safely	☐	☐	☐	☐	☐
Identifies expired or bad foods	☐	☐	☐	☐	☐
Handles raw meat correctly to avoid contamination	☐	☐	☐	☐	☐
Stores leftovers correctly	☐	☐	☐	☐	☐
Cooking					
Prepared pre-packaged/frozen food	☐	☐	☐	☐	☐
Follows simple recipe	☐	☐	☐	☐	☐
Measures ingredients	☐	☐	☐	☐	☐
Safely uses a sharp knife	☐	☐	☐	☐	☐
Cuts fruits/vegetables/ingredients	☐	☐	☐	☐	☐
Heats/cooks food on stove or in oven	☐	☐	☐	☐	☐
Uses toaster	☐	☐	☐	☐	☐
Uses coffee maker	☐	☐	☐	☐	☐

Household Skills

Will the applicant complete household chores regularly? ☐Yes ☐No

Please rate applicant's household skills

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance	Not Applicable
Household					
Sweeping	☐	☐	☐	☐	☐
Mopping	☐	☐	☐	☐	☐
Vacuuming	☐	☐	☐	☐	☐
Dusting	☐	☐	☐	☐	☐
Bathroom					
Cleaning toilets	☐	☐	☐	☐	☐
Plunging clogged toilet	☐	☐	☐	☐	☐
Cleaning tub/shower	☐	☐	☐	☐	☐
Laundry					
Sorts laundry	☐	☐	☐	☐	☐
Uses washing machine with correct amount of detergent	☐	☐	☐	☐	☐
Uses dryer	☐	☐	☐	☐	☐
Folds/hangs clothing	☐	☐	☐	☐	☐
Uses iron when needed	☐	☐	☐	☐	☐
Kitchen					
Washes dishes by hand in the sink	☐	☐	☐	☐	☐
Uses dishwasher	☐	☐	☐	☐	☐
Cleans counters	☐	☐	☐	☐	☐
Cleans spills in microwave or oven	☐	☐	☐	☐	☐

Keeps fridge clean	☐	☐	☐	☐	☐

Money Management Skills

1. Who currently pays the applicants bills? _____
2. Who is the representative payee for the applicant's benefits? _____
3. Will the applicant pay his/her own bills if he/she moves to Noah's Ark without assistance? ☐Yes ☐No

   If no, and assistance is needed, who will provide the assistance? ☐Family

   ☐Other_____

Please rate applicants Money management skills:

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance	Not Applicable
Budget					
Knows how much money he/she has or makes each month	☐	☐	☐	☐	☐
Knows how much bills cost	☐	☐	☐	☐	☐
Knows how to spend appropriately	☐	☐	☐	☐	☐
Does not run out of money prior to the end of the month	☐	☐	☐	☐	☐
Spending Money					
Uses debit card	☐	☐	☐	☐	☐
Uses credit card	☐	☐	☐	☐	☐
Uses cash-counts money correctly	☐	☐	☐	☐	☐
Identifies up to $100 bill	☐	☐	☐	☐	☐
Makes change when purchasing	☐	☐	☐	☐	☐
Paying Bills					
Writes checks	☐	☐	☐	☐	☐
Obtains money order	☐	☐	☐	☐	☐
Pays bills online	☐	☐	☐	☐	☐

Banking					
Checking bank balance	☐	☐	☐	☐	☐
Making deposits	☐	☐	☐	☐	☐
Making withdrawals	☐	☐	☐	☐	☐
Food stamps					
Manages food stamp spending	☐	☐	☐	☐	☐

Safety Skills

1. How long can the applicant be left alone without supervision? (select the highest level of time possible)
   ☐1-3 hours ☐4-6 hours ☐7-12 hours
   ☐13-16 hours ☐24 hours ☐Several days
   ☐Does not require supervision
2. Is the applicant able to sleep overnight without anyone checking on him/her? ☐Yes ☐No
3. Is the applicant able to secure his/her own apartment (locking doors, etc.) ☐Yes ☐No
4. Does the applicant know how to identify a stranger and know what to do if approached by a stranger? ☐Yes ☐No
5. Can the applicant safely navigate to familiar places in the community without supervision?

   ☐Yes ☐No

6. Is the applicant able to cross the street or walk through a parking lot safely without assistance? ☐Yes ☐No
7. Does the applicant understand the concept of sexual consent? ☐Yes ☐No
8. Does the applicant understand safe sex and protection from pregnancy and sexually transmitted diseases (STDs)? ☐Yes ☐No
9. Does the applicant know to call the landlord or apartment complex for emergency maintenance needs (i.e. plumbing, leak, etc.) ☐Yes ☐No
10. Does the applicant know how to safely evacuate the apartment in the event of an emergency? ☐Yes ☐No

Transportation Skills

1. How does the applicant typically get around the community? Check all that apply:
   ☐Drives a car ☐Rides a bike
   ☐Walks ☐Takes the bus
   ☐Takes a door-to-door bus service (i.e. Access Lynx)
   ☐Takes a car service (uber)
   ☐Driven by a family member/friend
2. Is the applicant able to follow simple directions to get somewhere? ☐Yes ☐No
3. Can the applicant arrange their own transportation to get somewhere when needed? ☐Yes ☐No

Mental Health and Behavioral Supports

1. Does the applicant currently receive psychiatric care? ☐Yes ☐No
2. Has the applicant ever received psychiatric care in the past? ☐Yes ☐No
3. Does the applicant have any mental health diagnoses? ☐Yes ☐No
   If yes, please check all current and past mental health diagnoses:
   ☐Bipolar Disorder ☐Schizophrenia
   ☐Depression ☐Anxiety Disorder
   ☐Obsessive Compulsive Disorder ☐ADHD/ADD
   ☐Borderline Personality Disorder ☐Intermittent Explosive Disorder
   ☐Other: (please specify) _____
4. Please indicate any current or behavioral challenges exhibited by the applicant:

	Within past 12 months	Within past 3 years	Longer than 3 years ago	Never exhibited
Self-injurious Behavior				
Head banging	☐	☐	☐	☐
Biting self	☐	☐	☐	☐
Cutting self	☐	☐	☐	☐
Hair pulling	☐	☐	☐	☐
Eye poking/gouging	☐	☐	☐	☐

Rumination (self-induced vomiting)	☐	☐	☐	☐
PICA (eating non- food objects)	☐	☐	☐	☐
Suicidal talk/threats	☐	☐	☐	☐
Suicide Attempt	☐	☐	☐	☐
Aggressive behavior				
Hits others	☐	☐	☐	☐
Kicks others	☐	☐	☐	☐
Bites others	☐	☐	☐	☐
Uses weapons against others	☐	☐	☐	☐
Threatens others	☐	☐	☐	☐
Stalks/harasses others	☐	☐	☐	☐
Bullies others	☐	☐	☐	☐
Inappropriate Sexual behavior				
Exposing self to others	☐	☐	☐	☐
Touching others without consent	☐	☐	☐	☐
Making inappropriate sexual comments	☐	☐	☐	☐
Public masturbation	☐	☐	☐	☐
Sexual interaction with minors (physical, verbal or online)	☐	☐	☐	☐
Destruction of Property				
Damages/breaks own possessions	☐	☐	☐	☐
Damages/breaks other possessions	☐	☐	☐	☐
Damages/breaks furniture or décor	☐	☐	☐	☐
Breaks windows	☐	☐	☐	☐

Sets fires	☐	☐	☐	☐
Inappropriate Social Behavior				
Throwing tantrums (stomping feet, sitting on the floor, aggressive gestures, etc.)	☐	☐	☐	☐
Cursing in inappropriate settings	☐	☐	☐	☐
Yelling at others	☐	☐	☐	☐
Stealing from others	☐	☐	☐	☐
Repetitive vocalizations	☐	☐	☐	☐

5. Has the applicant's behaviors resulted in medical treatment for self or others? ☐Yes ☐No
6. Has the applicant ever gone missing? ☐Yes ☐No
    a. If yes, was the police involved
    b. Where did the applicant go? _____
7. Has the applicant ever been confined under the Bakker Act? ☐Yes ☐No
   If yes please provide date(s) and reasons for confinement: _____

   _____
8. Has the applicant ever been arrested? ☐Yes ☐No

   If yes, please provide date (s) and explanation: _____

   _____
9. Has the applicant ever been convicted of a crime? ☐Yes ☐No
   If yes, please provide date(s) and explanation: _____

   _____
10. Is the applicant registered sexual offender? ☐Yes ☐No
    If yes, does he/she have any restrictions?_____
11. Please describe how the applicant expresses frustration or anger: _____

    _____
12. Does the applicant have a current behavior plan? ☐Yes ☐No
    If yes, what are the behaviors identified in the plan? _____

    _____
13. Are the environmental modifications needed to minimize any problem behaviors specified above? ☐Yes ☐No
    If so, please specify:_____

    _____

Additional Applicant Information

Are you a smoker? ☐Yes ☐No

Have you ever been asked to move out by a landlord? ☐Yes ☐No

Have you ever breached a lease or rental agreement? ☐Yes ☐No

Have you ever had an eviction filed against you? ☐Yes ☐No

Have you intentionally refused to pay rent when due? ☐Yes ☐No

Do you currently owe money to a landlord? ☐Yes ☐No

Have you ever lost property in a foreclosure? ☐Yes ☐No

Have you ever been arrested for or convicted of a felony? ☐Yes ☐No

If yes, explain: _____

Are there any criminal matters pending against you? ☐Yes ☐No

Have you filed for bankruptcy? ☐Yes ☐No

If yes, when? _____

Expectations

Please describe why you would like to live in one of the Noah's Ark properties?

_____

_____

I understand that the information provided will be used to assess suitability for independent living nd identify needed supports for the applicant.

I understand that completion of this application does not guarantee residency at a Noah's Ark of Central Florida property.

I understand that all information provided will be kept confidential and stored according to all regulatory requirements.

I agree that all of the information provided on this survey is true and accurate and that no information has been omitted.

Signature: _____ Date_____

Applicant

Signature: _____

Person assisting with this application

Noah's Ark of Central Florida

Empowering people who have developmental disabilities to live, laugh and love

RESIDENT SUPPORT FORM

Noah's Ark does not provide supports for our residents. Our applicants and families acknowledge that there are certain areas where supports are needed for an individual to be successful in an independent living community. Therefore we need to determine that the adequate supports are/will be, in place. This form will indicate the plan for support of the resident. If the appropriate level of support are not provided or maintained throughout the duration of the lease term this could potentially affect the lease renewal.

☐ **Medicaid Home and Community Based Waiver Services (MED WAIVER):** Resident receives support services through the Florida Medicaid Waiver program and all adequate support services will be provided through that program.

Support Coordinator Name_____ **Phone Number**_____

Support Provider Name: _____ **Phone Number:** _____

Support Provider Name:_____ **Phone Number**:_____

☐ **Medicaid Consumer Directed Care Service (CDC +):** Resident receives support services through the Florida Medicaid Waiver program and all necessary support services will be provided through that program.

Consultant Name: _____ **Phone Number:** _____

Representative Name: _____ **Phone Number:** _____

☐ **Private Pay Services:** Resident's not receiving support services through a government agency and is privately paying a company to provide support services.

Support Provider Company: _____ **Phone Number:**
_____

Support Provider Name:_____ **Phone Number:**_____

Please circle yes or no if the resident is completely independent with the following support categories. If the resident is <u>not</u> completely independent please indicate who will be providing additional support by circling parent/family or the support provider.

Supports **Categories of supports residents need:**	**Resident** **Yes | No**	**Parents/Family or** **Support provider**
Grocery shopping	Yes | No	Family or Support
Transportation	Yes | No	Family or Support
Personal Care & Hygiene	Yes | No	Family or Support
Administering Medications	Yes | No	Family or Support
Bathroom Cleaning	Yes | No	Family or Support
Shared area cleaning in apartment	Yes | No	Family or Support
Washing Dishes	Yes | No	Family or Support
Laundry	Yes | No	Family or Support
Vacuuming/Mopping	Yes | No	Family or Support
Personal Finances & Money Management	Yes | No	Family or Support
Meal Preparation	Yes | No	Family or Support
Disposal of Expired Food from Refrigerator	Yes | No	Family or Support
Scheduling Appointments (Medical, Dental, etc.)	Yes | No	Family or Support
Please note these are not applicable for the resident to be completely independent		
Emotional, Social & Relationship Support and Skills		
Maintaining Government Benefits (i.e. Food Stamps)		
Teaching Emergency Evacuation Procedure		
Medication Monitoring-(i.e. Ensuring meds are working/dosage is correct)		

By signing this I covenant and agree to follow through with my responsibilities to ensure support services are provided as listed on this Resident Support Form. I understand that not providing the adequate supports listed above may result in a recommendation to Royal American Management (RAM) for non-renewal of the lease.

_____ _____

Parent/ Guardian Signature Date

Suggested List of Mental Health Evaluations Providers

Note: When calling to make an appointment, please identify yourself as a potential Noah's Ark Resident.

I. **Tracey G. Henley, Psy.D., ABPP**
Phone: 863-701-9202
Psychological and Neurobehavioral Services, P.A.
631 Midflorida Drive Lakeland, FL 33813
Email: admin@neuropsychologyfl.com
http://neuropsychologyfl.com/

II. **Rick Zalanka- MS LMHC, P.A.**
Phone: 863-701-8700
Address: 190 Fitzgerald Rd Ste 1, Lakeland, FL 33813
https://www.counselingserviceslakeland.com/

Family Life Services Counseling
Alicia Heningburg/Sherri Nopper
Phone: 407-518-9505
345 W Oak St
Kissimmee, Fl 34741
Email: familylifeservicescounseling@gmail.com

These Counselors are NOT employed by or directly connected to the Noah's Ark Organization.