



## Initial Applicant Survey

*Quest Village is a comfortable, accessible, residential community that provides adults with disabilities access to opportunities that foster independence. This initial applicant survey allows for an evaluation of all potential residents who live at Quest Village to determine if the facilities can adequately meet the needs of each resident.*

*Please note that completing the Initial Applicant Survey form does NOT secure residence nor determine eligibility and does NOT put the applicant on a waiting list for Quest Village. Please be aware, there is NOT a waiting list for Quest Village. If you have any questions about this form, please contact us at [info@questvillage.org](mailto:info@questvillage.org) or 407-317-5359.*

Applicant name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of person completing this survey: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Referred by: \_\_\_\_\_

### SECTION 1: PERSONAL INFORMATION

#### Applicant Information

Current street address: \_\_\_\_\_

City, state, zip code: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

Current living arrangement (please check one):

Living in family household with parent/guardian

Living in a group home

Living in an assisted living facility

Living alone in an apartment/house in the community

Living with roommates in an apartment/house in the 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 (If Yes, how long \_\_\_\_\_)

Has the applicant been diagnosed with or considered to have an intellectual and/or developmental disability?      No      Yes (If Yes, diagnosis \_\_\_\_\_)

Is the applicant a legally competent adult?      Yes      No

Does the applicant have a legal guardian?      Yes      No

Does the applicant have a guardian advocate?      Yes      No

## Applicant Demographics

Gender:            Male            Female            Age: \_\_\_\_\_            Race: \_\_\_\_\_

Marital status:            Single            Engaged            Married            Divorced            Widowed

Do you have any children living with you?            No            Yes (If Yes, age(s) \_\_\_\_\_)

## Applicant Financial Status

Is the applicant currently employed?            Yes            No

Estimated monthly income from employment \$ \_\_\_\_\_

Would this job continue if the applicant moved to Quest Village?            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 \$ _____
Trust fund	amount \$ _____
Parent/guardian financial supplement	amount \$ _____

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

If Yes, please indicate source of funding:

Medicaid Waiver	Consumer Directed Care (CDC)
General Revenue (GR)	Other: _____

Does the applicant currently receive services through Department of Vocational Rehabilitation (VR)?            Yes            No

If No, please indicate status with VR:

Has not applied for VR services

Has been denied VR services

Has applied and is in the process to determine eligibility

Has been waitlisted for VR services

Currently receiving VR services

Indicate agency providing support: \_\_\_\_\_

If needed, who will sign as the guarantor on the lease and/or service agreement (if applicable) on behalf of the applicant?

Name: \_\_\_\_\_            Relationship to applicant: \_\_\_\_\_

## Guardian or Primary Contact Information

Name(s): \_\_\_\_\_

Street address: \_\_\_\_\_

City, state, zip code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## SECTION 2: SERVICE INFORMATION

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

Personal Supports / In-Home Supports	Agency: _____
Supported Employment	Agency: _____
Supported Living Coaching	Agency: _____
Residential Habilitation (group home)	Agency: _____
Adult Day Training	Agency: _____
Companion Services	Agency: _____
Behavior Analysis	Agency: _____
Transportation Services	Agency: _____
Nursing Home / Home Health Care	Agency: _____

The following services will be offered at Quest Village; please indicate which services applicant may need in order to be successful (select all that apply):

On-site services to assist with daily tasks in their apartment

- Level of service is based on need but can include assistance with routine tasks as taking medications, personal hygiene, cooking meals, and laundry.

Off-site services to assist with community based tasks

- Level of service is based on need but can include assistance with tasks such as paying bills, medical appointments and grocery shopping.

Housekeeping services in their apartment

## SECTION 3: APPLICANT SKILLS

### Daily Living Skills

1. If the applicant lives or lived independently in the past, please list some daily living skills that he/she can demonstrate without assistance: \_\_\_\_\_
2. If the applicant lives or lived independently in the past, list some areas in which he/she require additional training: \_\_\_\_\_

3. Is the applicant able to independently wake at the appropriate time in the morning? Yes No
4. Will the applicant get up without prompting to start the day? Yes No
5. What time does he/she usually wake? \_\_\_\_\_ am/pm
6. Will the applicant shower daily without prompting? Yes No
7. Does the applicant use any sort of incontinence supplies (i.e. pull-ups, urinary pads, bed liners, etc.)?  
 No Yes (If Yes, is the applicant independent in the use? Yes No)
8. Please rate the applicant's hygiene tasks:

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Showering</b>				
Washing body well enough to ensure adequate hygiene				
Washing hair and rinsing well enough to remove all shampoo/conditioner				
<b>Toileting</b>				
Gets to the restroom in time to prevent accident(s)				
Adequately wipes/cleans self				
Uses appropriate amount of toilet paper to prevent toilet clogs				
Washes hands after using the restroom				
Uses incontinence supplies correctly, if applicable				
<b>Shaving</b>				
Knows what parts of the body to shave				
Safely shaves all necessary parts				
<b>Dressing</b>				
Chooses weather appropriate clothing				
Chooses work appropriate clothing or uniform when scheduled to work				
Chooses matching clothing				
Chooses matching clothing				
Chooses appropriate shoes for the setting/activity				
Puts on all clothing correctly				

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Hygiene</b>				
Applies deodorant daily				
Brushes teeth twice daily, covering the entire mouth well enough to clean all teeth				
Uses appropriate amount of toothpaste				
Cares for dentures properly, if applicable				
Brushes & styles hair appropriately				
Puts on glasses/contacts				

### Medical Needs & Skills

1. Does the applicant currently take any prescription medication(s)?                      Yes                      No

If Yes, please list medications and reason taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Does the applicant know what medications he/she takes and why?                      Yes                      No

3. Describe the process and level of assistance needed for the applicant to take prescription medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. How does the applicant get their medication from the pharmacy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Describe the process and level of assistance needed for the applicant to treat simple medical issues (i.e. cold, headache, cramps, cough, constipation, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Does the applicant have any allergies? Yes No

If Yes, what are they and what type of reaction(s)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the applicant require use of an EpiPen or other emergency treatment for allergic reaction? Yes No

7. Does the applicant have seizures? Yes No

If Yes, what type? \_\_\_\_\_

How long do seizures typically last? \_\_\_\_\_ minutes

When was the applicant's last seizure? \_\_\_\_\_

8. Who currently schedules the applicant's medical appointments? \_\_\_\_\_

9. How does the applicant get to medical appointments? \_\_\_\_\_

10. For female applicants, does she have a regular menses? Yes No

If Yes, is the applicant able to correctly use feminine hygiene supplies without assistance? Yes No

If assistance is required, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. 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)

Communication device Type: \_\_\_\_\_

Glasses/contacts

12. What assistance, if any, is needed for the applicant to transfer or move from one location to another (pivot, lift, etc.)? \_\_\_\_\_

\_\_\_\_\_

## Dietary Needs & Skills

1. Does the applicant eat meals and snacks independently? Yes No
2. Does the applicant require any special dietary requirements (i.e. diabetic diet, gluten-free, reduced calorie/weight management, low salt, etc.)? Yes No

If Yes, describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Does the applicant require any specialized food/beverage texture? Yes No

If Yes, please indicate the appropriate texture:

Pureed Ground Chopped Mechanical Soft Thickened Liquids

4. Who is currently responsible for ensuring that the applicant follows dietary requirements and textures in their current living situation? \_\_\_\_\_
5. Are there any mealtime safety concerns for the applicant (e.g. choking, aspiration, stuffing mouth, etc.)? Yes No

If Yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Does the applicant have an eating disorder (current or past history)? Yes No

If Yes, please explain: \_\_\_\_\_

7. Please rate applicant's dietary and cooking skills:

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Meal Planning</b>				
Chooses meals to prepare				
Makes grocery list according to diet				
Chooses correct items at grocery store				
<b>Food Handling &amp; Storage</b>				
Stores groceries appropriately (refrigerator, freezer or pantry)				
Thaws food safely				
Identifies expired or bad foods				
Handles raw meat correctly to avoid contamination				
Stores leftovers correctly				

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Cooking</b>				
Prepares pre-packaged foods				
Follows a simple recipe				
Measures ingredients				
Safely uses a sharp knife				
Cuts fruits/vegetables/ingredients				
Heats/cooks food in the microwave				
Cooks food on the stove				
Cooks food in the oven				
Uses a toaster				
Uses a coffee maker				

8. Can the applicant identify healthy vs. unhealthy foods? Yes No
9. What does the applicant typically eat for breakfast? \_\_\_\_\_
10. Can the applicant prepare his/her own breakfast? Yes No
11. What does the applicant typically eat for lunch? \_\_\_\_\_
12. Can the applicant prepare his/her own lunch? Yes No
13. What does the applicant typically eat for dinner? \_\_\_\_\_
14. Can the applicant prepare his/her own dinner? Yes No

### Household Skills

1. Will the applicant complete household chores regularly? Yes No
2. Please rate applicant's household skills:

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Household</b>				
Sweeping				
Mopping				
Vacuuming				
Dusting				



	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Bathroom</b>				
Cleaning toilets				
Plunging a clogged toilet				
Cleaning tub/shower				
<b>Laundry</b>				
Sorts laundry				
Uses washing machine with correct				
Uses dryer				
Folds/hangs clothing				
Uses iron when needed				
<b>Kitchen</b>				
Washes dishes by hand in the sink				
Uses dishwasher				
Cleans counters				
Cleans spills in microwave or oven				

### Money Management Skills

- Who currently pays the applicant's bills? \_\_\_\_\_
- Who is the representative payee for the applicant's benefits? \_\_\_\_\_
- Will the applicant pay his/her own bills if he/she moves to Quest Village (with or without assistance)?  

Yes
No

If Yes and assistance is needed, who will provide the assistance?

Quest Village Staff      Family      Other \_\_\_\_\_

- Please rate applicant's money management skills:

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Budget</b>				
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				

	Completely Independent	Needs Reminders	Needs Some Assistance	Needs Total Assistance
<b>Spending Money</b>				
Uses debit card				
Uses credit card				
Uses cash—counts money correctly				
Identifies up to \$100 bill				
Makes change when purchasing				
<b>Paying Bills</b>				
Writes checks				
Obtains money order				
Pays bills online				
<b>Banking</b>				
Checking bank balance				
Making deposits				
Making withdrawals				
<b>Food Stamps</b>				
Manages food stamp spending				

## Safety Skills

1. How long can the applicant be left along 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, windows, 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. Does the applicant know how to identify an emergency and able to call 911 independently? Yes No

6. Does the applicant know to turn off or unplug heated appliances when not in use such as stove, oven or iron?  
Yes No

- |   |     |                 |
|---|-----|-----------------|
| 4. Can the applicant safely navigate to familiar places in the community without supervision?   | Yes | No              |
| 5. Is the applicant able to cross the street or walk through a parking lot safely without assistance?   | Yes | No              |
| 6. If the applicant smokes, does he/she know how to safely dispose of and/or store cigarettes/cigars/pipes in order to prevent fires?           | Yes | No              |
|   |     | N/A, Non-smoker |
| 7. If the applicant smokes, has he/she ever fallen asleep with a lit cigarette/cigar/pipe?  | Yes | No              |
|   |     | N/A, Non-smoker |
| 8. Does the applicant understand the concept of sexual consent?   | Yes | No              |
| 9. Does the applicant understand safe sex and protection from pregnancy and sexually transmitted diseases (STDs)?                               | Yes | No              |
| 10. Does the applicant know to call their landlord or apartment complex for emergency maintenance needs (i.e. plumbing leak, A/C broken, etc.)? | Yes | No              |

### Transportation Skills

- 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 (i.e. Uber)
  - Driven by a family member/friend
- Is the applicant able to follow simple directions to get somewhere? Yes No
- Can the applicant arrange their own transportation to get somewhere when needed? Yes No

### SECTION 4: MENTAL HEALTH & 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 indicate all current or 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 past behavioral challenges exhibited by the applicant:

	Within past 12 months	Within past 3 years	Longer than 3 years ago	Never exhibited
<b>Self-Injurious Behavior</b>				
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				
<b>Aggressive Behavior</b>				
Hits others				
Kicks others				
Bites others				
Uses weapons against others				
Threatens others				
Stalks/harasses others				
Bullies others				
<b>Inappropriate Sexual Behavior</b>				
Exposing self to others				
Touching others without consent				
Making inappropriate sexual comments				
Public masturbation				
Sexual interaction with minors (physical, verbal or online)				
<b>Destruction of Property</b>				
Damages/breaks own possessions				
Damages/breaks others possessions				
Damages/breaks furniture or décor				
Breaks windows				
Sets fires				

	Within past 12 months	Within past 3 years	Longer than 3 years ago	Never exhibited
<b>Inappropriate Social Behavior</b>				
Throwing tantrums (e.g. 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 behavior ever resulted in medical treatment for self or others? Yes No
6. Has the applicant ever gone missing? Yes No  
 If Yes, was police involved? Yes No  
 Where did the applicant go? \_\_\_\_\_
7. Has the applicant ever been confined under the Baker 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 a 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 environmental modifications needed to minimize any problem behaviors specified above? Yes No  
 If so, please specify: \_\_\_\_\_  
 \_\_\_\_\_

**SECTION 5: CONCLUSION**

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

I understand that completion of this survey does not constitute a rental application, nor does it guarantee residency at Quest Village.

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.

<hr/>	<hr/>
Signature of person completing survey	Date
<hr/>	
Printed name of person completing survey	
 <hr/>	 <hr/>
Signature of applicant	Date
<hr/>	
Printed name of applicant	

**SECTION 6: REVIEW & EVALUATION** *(To be completed ONLY by staff member of Quest, Inc.)*

Comments: 

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Signature of staff member completing evaluation	Date
<hr/>	
Printed name of staff member completing evaluation	

[Completed packets and supporting documentation can be sent via email to info@questvillage.org.](mailto:info@questvillage.org)