OCT Residential Program

Please select the desired Residential Model:

- OCT Residential (The Fountains at UNF)
- OCT Residential (The District on Kernan)
- Extended Services (Supported Living)

Please note that this application will serve two purposes: (1) It will give the OCT Residential Coordinator and administration tools to assess the appropriateness of the program and (2) it will serve as a guide to Residential staff working with you. Please be as accurate and detailed as possible in order to maximize the benefits of Residential Support.

*Note to Parent(s)/Guardian(s): Please allow the applicant to fully answer each application item. You are welcome to provide assistance in writing responses for your applicant.*
Application Check List

This check list is to help ensure all information if filled out and all documentation is included before submitting the application.

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<th>Office Use</th>
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|                  | Medical Documentation  
(allergies, special dietary requirements, etc) |
|                  | Letter of Recommendation  
(at least one non-family member who can provide insights into the strengths and weakness of the applicant that pertains to independent living and social behaviors) |
|                  | Photograph (headshot) of Applicant |
|                  | Copy of Photo I.D. |
|                  | Copy of Medical Insurance Card |
|                  | Power of Attorney/Guardianship/Medical Proxy/Documentation  
(if applicable) |
|                  | Signed Acknowledgement/Wavier/Release of Liability Form |
## Eligibility Requirements

<table>
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1. Be at least 18 years of age  
2. Have an intellectual/developmental disability  
3. Be eligible for / or receiving SSDI or SSI  
4. Have health insurance (Medicaid, Medicare, Private)  
5. Applicant has a desire to receive independent living experience services in an apartment setting that focuses on improved outcomes of independent living.  
6. Be able to independently self-administer medicines*  
7. Have exhibited an interest and desire for greater independence, and parent/guardian support in the pursuit of independence  
8. Be able to navigate independently within the apartment complex  
9. Be willing to learn and use alternative modes of travel, such as public transportation or The District Apartment Shuttle  
10. Be receptive to learning financial management and live within a restricted budget  
11. Must possess or willing to learn time management skills and be able to follow a schedule with/without accommodations (i.e., picture schedule)  
12. Have socially adaptive and responsible behaviors when left unsupervised and have follow/adhere to rules and instruction.  
13. Be independent in grooming and hygiene routines *  
14. Be able to communicate with others effectively with/without accommodations  
15. Before entering the program, participant must have a cell phone  
16. Must be willing to interview (in person or video chat)  

*Residential staff does not have certification required to provide medication management or serve as personal care assistants. If these services are required, the family will need to contract with private providers for personal care and/or medical management during the program.

By signing this form, the potential participant and his or her parent(s)/guardian(s) acknowledge having read and understood the basic eligibility requirements for the OCT Residential Program. This form must be signed and be included in the application packet. It must also be noted that this form includes ONLY the basic eligibility requirements. Final acceptance to the program will be determined by the Admissions Committee.

Parent/Guardian Signature_________________________________ Date__/___/____

Participant Signature_______________________________________ Date__/___/____

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Residential Application

Please provide a recent photograph of the applicant along with this form. Be sure to complete all sections of the application.

Section 1: Personal Information

A. Resident’s Information

Name of Resident___________________________________ Nickname_____________________

Address______________________________________________________

City_____________________________ State________________ ZIP ______________

Home Phone___________________________ Alternate Phone_____________________

Date of Birth________________________ Age____________ Sex_____________

Social Security Number ____________________________

Primary Disability___________________________________________

Secondary Disability___________________________________________

B. Parent/Guardian Information

Resident currently resides with: □Mother □Father □Both □Foster Parent □Group Home

□ Other________________________

1. Parent/Guardian Information (Primary Contact)

Name__________________________

Address______________________________________________________

City_____________________________ State________________ ZIP ______________

Home Phone___________________________ Alternate Phone_____________________

Email Address__________________________

2. Parent/Guardian Information (Alternative Contact)

Name__________________________

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C. Demographic

1. Have you ever been away from home before? □ Yes □ No

If “Yes,” where did you go and how long were you away from home? Did you enjoy that experience?

2. What high school did you attend (name/location)?

____________________________________________________

Did you graduate from high school? □ Yes □ No

If “Yes,” did you graduate with a special diploma? □ Yes □ No  Year: _____________

3. If you have graduated from high school, please list what you have done since graduation (ex. Work, volunteer, community-based training, leisure activities, etc.)

____________________________________________________

____________________________________________________

____________________________________________________

4. Please list any and/all community work experiences (indicate if experience was paid or volunteer, as well as duration)

____________________________________________________

____________________________________________________

____________________________________________________

5. Do you smoke? □ Yes □ No  Quantity per week: ______________

6. Do you drink alcoholic beverages? □ Yes □ No  Frequency: ______________

7. Have you ever been arrested? □ Yes □ No

If “Yes,” please describe the following:

Date: ____________________________
Arresting Charge: ____________________________ □ Misdemeanor □ Felony

Were you convicted? □ Yes □ No

If “Yes,” please describe your sentence:

______________________________________________

Section 2:

Disability, Impairment, Challenge, or Condition and Medical Information

Please use space provided to answer the questions and elaborate as much as possible, and feel free to add extra pages if necessary.

A. Disability or Condition (Please check all that apply)

□ Down Syndrome □ Attention Deficit Hyperactivity Disorder
□ Cerebral Palsy □ Autism
□ Prader/Willi Syndrome □ Emotional Disorder (Bipolar, Depression, etc.)
□ Spina Bifida □ Muscular Dystrophy
□ Chromosome Abnormality (Diagnosis/Explain)

______________________________

□ Intellectual Disability (Diagnosis/Explain)

______________________________

□ Deaf/Hearing Impaired (Diagnosis/Explain)

______________________________

□ Speech Disorder (Diagnosis/Explain)

______________________________

□ Blind/Visual Impairment (Diagnosis/Explain)

______________________________

□ Other

______________________________
1. Do you currently receive private therapeutic services, such as physical therapy, occupational therapy, psychiatry, speech therapy, or behavioral therapy? If yes, please list

___________________________________________________________________________
___________________________________________________________________________
____________________________________________
___________________________________________________________________________
___________________________________________________________________________

2. Please list any significant medical and/or physical conditions that may impact your participation in social and/or recreational activities within the program (for example: severe allergies or visual disability)

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

3. Please list all medications that you are currently taking. Include the dosage/frequency, purpose of the medications, and any side effect(s):

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Are you independent in self-administering medications and remembering to take medication?* □ Yes □ No

*Please note that Residential Services does not have a nurse or any other medical personnel.

3. Do you have seizures? □ Yes □ No

Type ________________________ Duration ________________________

Frequency ____________________ Date of last seizure ____________________

Are seizures controlled with medications? □ Yes □ No

4. Please list any assistive technology that you use (i.e., wheelchair, eyeglasses, prosthesis, walker, hearing aid, roll aid, etc.) and if you require accessibility accommodations.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

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Section 3: A little bit about you

Hobbies and Interests

Cooking ____  Concerts ____  Baseball ____
Baking ____  Theater ____  Swimming ____
Arts/Crafts ____  Board Games ____  Running/Jogging ____
Gardening ____  Decorating ____  Museums ____
Reading ____  Working out ____  Amusement Parks ____
Writing ____  Golf ____  Eating at Restaurants ____
Beach ____  Tennis ____  Shopping ____
Movies ____  Basketball ____  Watching TV ____
Musical Instrument ____  Soccer ____
Dancing ____  Volleyball ____  Video Games ____
Acting ____  Softball ____

1. List any clubs or organizations in which you currently participate.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

2. If your applicant desires to participate in religious services, please indicate the religious preference. (Staff will assist in making arrangements for public transportation to and from services)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Answer Key

“Y” = Yes you already do this
“N” = No, you have no interest
Please use this answer key for the following “skills” sections:

**Answer Key**

- "Y" = Yes, I already do this
- "N" = No, I have no interest
- "A" = I can do this with assistance

### Transportation Skills:

- ____ How to read a map
- ____ How to use a city bus schedule
- ____ How to ride the city bus
- ____ How to ask others for directions
- ____ Crossing the street
- ____ Crosses street with crosswalk
- ____ Crosses 2 lanes with light
- ____ Crosses 2 lanes without light
- ____ Crosses 4 + lanes with light
- ____ Crosses 4+ lanes without light
- ____ Able to utilize a city taxi
- ____ Able to utilize a shuttle service

Specifics/Comments: 

---

### Financial Management Skills:

- ____ Able to count money
- ____ Able to estimate cash back from a transaction
- ____ Using Cash to purchase items at a store
- ____ Using a calculator to estimate costs during shopping (i.e. calculating sales tax and total items)
- ____ Using a Debit Card
- ____ Keeping track of debit card spending (i.e. keeping receipts and recording spending)
- ____ Using a Credit Card
- ____ Keeping track of credit card spending (i.e. keeping receipts and recording spending)
- ____ Developing a budget
- ____ Remaining within a budget
- ____ Balancing a checkbook
- ____ Organizing your Wallet
Please provide any additional information that would be helpful for Residential staff in your ability and challenges in financial management.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Household Chore Skills:

___ Dusting  ___ Using a dishwasher
___ Sweeping  ___ Doing Laundry
___ Vacuuming  ___ Ironing
___ Cleaning Mirrors  ___ Cleaning bathtubs
___ Polishing  ___ Cleaning toilets
___ Washing dishes by hand  ___ Removing stains from carpets

Please list any additional chores activities that you know how to do and/or require further assistance in learning.

____________________________________________________________________________
____________________________________________________________________________

Culinary Skills:

___ Cutting Vegetables
___ Cutting Fruits  ___ Using a Stove
___ Cutting Meats  ___ Following Simple Recipe
___ Using a Microwave  ___ Using a dishwasher
___ Using an Oven  ___ Using a toaster
1. What types of breakfast meals do you usually eat and can you prepare these by yourself? If not, what are some breakfast meals are you able to prepare without assistance?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

2. What types of lunch and dinner meals do you usually eat?

____________________________________________________________________

____________________________________________________________________

3. What types of lunch meals are you able to prepare by yourself without assistance?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

4. Have you ever made meals from the following semi-prepared meal boxes: Hamburger Helper, Campbell’s, Pasta Side Dishes, etc.? If yes, how did it turn out?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

5. What type of meals would you like to learn how to cook?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

6. Do you know how to use kitchen appliances in a safe manner? Please describe.

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
7. What are your favorite types of meals and foods?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

8. What is your favorite type of restaurant? (ex. Italian, Chinese, Japanese, Mexican, etc.).

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

9. Do you ever eat frozen foods? If so, which ones? (ex. Lean Cuisines, Hot Pockets, etc.).

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

10. What foods do you not like?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

11. Do you eat a healthy balance between fruits, vegetables, meats, and dairy products?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

12. Are you currently on and/or follow a diet, special diet (due to allergies/illnesses), religious preference, have nutritional goals, etc.? (Please Explain)

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Stamina and Endurance

Please check the item that describes you the best:

1. **Strength – Lifting and Carrying:**
   ___ Poor (<10 lbs) ___Fair (10-20 lbs) ___Average (30-40 lbs) ___Strong (>50 lbs)

   Specifics/Comments: -

2. **Endurance in completing tasks: (without breaks)**
   ___Works <2 hours ___Works 2-3 hours ___Works 3-4 hours

   Specifics/Comments: -

3. **Orienting:**
   ___Small Area ___One Room ___Several Rooms ___Building Wide ___Building & Grounds

   Specifics/Comments: -

4. **Physical Mobility: (Please check all that apply)**
   ___Sit/stand ___Fair ambulation ___Difficulty with stairs/minor obstacles ___Full mobility

   Specifics/Comments: -

5. **Gross Motor Ability:**
   ___Full ___Fair ___Minimal

   Specifics/Comments: -
6. Fine Motor Ability:

___Full  ___Fair  ___Minimal

Specifics/Comments: -

7. Independent Work Rate: (no prompts)

___Slow pace  ___Steady/average

___Above average/sometimes fast pace  ___Continual fast pace

Specifics/Comments: -

8. Attention to task/perseverance:

___Frequent prompts with high supervision  ___Some prompts with high supervision

___Frequent prompts with low supervision  ___Some prompts with low supervision

___ No prompts Required

Specifics/Comment: -

9. Independent task sequencing:

___Cannot perform tasks in sequence  ___Performs 4-6 tasks in sequence

___Performs 2-3 tasks in sequence  ___Performs 7 or more tasks in sequence

Specifics/Comments: -
10. **Initiative/Motivation:**

   ___Always seeks work  ___Sometimes volunteers  ___Waits for direction  ___Avoids
   next task

   Specifics/Comments: -  
   

11. **Adapting to Change:**

   ___Adapts to change  ___Adapts to change with great difficulty
   ___Rigid routine required  ___Adapts to change with some difficulty

   Specifics/Comments: -  
   

12. Do you need prompting (verbally) to complete a task? If so, what kind of verbal
    prompting do you need and how frequently? Please list some specific tasks that
    require prompting.

    ____________________________________________________________
    ____________________________________________________________

13. What positive reinforcements work best to keep you motivated to continue and
    complete tasks? (Ex. Verbal praise, candy, trip to the store, etc.).

    ____________________________________________________________
    ____________________________________________________________

14. What is the best way for staff to motivate you to accomplish a goal or follow
    instructions?

    ____________________________________________________________
    ____________________________________________________________
Functional Skills

Please check off what applies to you. Please provide comments and explanations.

1. **Time Awareness:**
   - ___Unaware of time and clock function
   - ___Can tell time to the hour
   - ___Can identify breaks and lunch
   - ___Can tell in hours and minutes

   Specifics/Comments: -

2. **Functional Reading:**
   - ___None
   - ___Sight words/symbols
   - ___Simple reading
   - ___Fluent reading

   Specifics/Comments: -

3. **Functional Math:**
   - ___None
   - ___Simple counting
   - ___Simple addition/subtraction
   - ___Computation skills

   Specifics/Comments: -

4. **Following Directions or Instructions:** (Please check all that work best for you)
   - ___Detailed written instructions
   - ___Simple written instructions
   - ___Simple written instructions with pictures
   - ___Simple checklist with pictures
   - ___Simple checklist without pictures
   - ___Repetition
   - ___Modeling (use of demonstrations)
Hygiene Routines

Please describe your full daily hygiene routine and procedures (also list level of assistance needed, for instance, prompting, modeling, or picture schedule). Please indicate when you prefer to take showers (am or pm).

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
What time do you usually go to sleep?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
What is the best way to motivate you in engaging the hygiene routine?

____________________________________________________________________________
____________________________________________________________________________
Personality and Interpersonal Relationships

1. Please check-off the given answer(s) that best describe your personality:
   ___ I am very talkative
   ___ I am quiet
   ___ I take some time to open up to people
   ___ I like being around a lot of friends
   ___ I like to be by myself sometimes
   ___ I get nervous when I am in large crowds
   ___ I find it easy to make friends
   ___ I like to go to parties
   ___ I would rather stay home and read a book
   ___ I am happy most of the time
   ___ I sometimes get depressed or anxious
   ___ I can be moody sometimes
   ___ I get angry a lot
   ___ I am always able to see the bright side of everything
   ___ I know how to entertain myself
   ___ I prefer quiet environments
   ___ I am not afraid to try new things

2. Handling Criticism/Stress: (Please indicate how you react)
   ___ Resistive/argumentative
   ___ Withdraw into silence
   ___ Accept criticism/do not change behavior
   ___ Accept criticism/change behavior

Specifics/Comments:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

3. What event/activities make you feel upset?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
4. What is the best way for you to cope when you are upset?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

5. Do you have any fears or phobias? Do these fears or phobias interfere with daily activities in your life?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

6. How well do you generally get along with others?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

7. If you have mood swings, what is the best way to help you?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

8. Please provide additional insight into your personality and the way you interact with others that would be helpful for in assisting you with socialization skills training activities and facilitating friendships:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________
Please Read and Sign

I understand that this application is for admission to The Arc Jacksonville OCT Residential program and acceptance is conditional upon receiving evidence to confirm the information in this document, as well as information provided through the interview process. By signing this document, I am certifying that the information given is complete and accurate, and I understand that to make false or fraudulent statements within this application may result in denial of admission. If admitted, I hereby agree to abide by the policies, rules, and regulations of The Arc Jacksonville OCT Residential Program. Should any of the information change prior to my enrollment in the program, I shall notify the OCT Residential Program immediately.

Applicant’s Signature_____________________________________________ Date_______

Parent/Guardian’s Signature________________________________________ Date_______

Ensure that all sections have been completed. Failure to complete all application sections and to provide the required non-refundable application fee may result in delayed review of application and/or non-acceptance.

Application Fee:

• Please enclose a non-refundable application fee of $25 with your application.

• Please make your check or money order payable to: The Arc Jacksonville

• Please indicate in the “Memo” section: Residential Application

• Please send the OCT Residential application and fee to:

  On Campus Transition at the University of North Florida
  ATTN: LIFE Experience
  1 UNF Drive (Building 57, Room 2800)
  Jacksonville, FL 32224

  (904)620-3890