PLEASE CIRCLE YES OR NO ANSWER

LEGAL ISSUES	Y	N	WHAT KIND			
CONTACT NAME & NUMBER						
HISTORY OF VIOLENCE	Y	N	DIRECTED TOWARDS	*HUMANS*	OR	*ANI MALS*
WAS IT PHYSICAL	Y	N	WEAPON(S) INVOLVED	Y		N
WHAT TYPE(S) OF WEAPON						
HISTORY OF BEING VERBALLY VIOLENT	Y	N				
SELF HARMING	Y	N	HISTORY OF SELF HARM	Y		N
DISABILITY/DIAGNOSIS (PLEASE LIST)						
MEDICATION COMPLIANCE	Y	N	INDEPENDENT		DEPENDENT	
MOBILITY ISSUES	Y	N	INDEPENDENT		DEPENDENT	
USE OF ASSISTED WALKING DEVICE	Y	N	WHAT KIND			
MEMORY ISSUES	Y	N	DEMENTIA	Y	N	
ORIENTATION ISSUES	Y	N	WHAT KIND			
TOILETING ISSUES	Y	N	WHAT KIND			
PERSONAL HYGIENE ISSUES	Y	N	WHAT KIND			
HIV/AIDS CASE MANAGER						
PHONE NUMBER			FAX NUMBER			
MENTAL HEALTH CASEMANGER						
PHONE NUMBER			FAX NUMBER			
PRIMARY CARE PHYSICIAN						
PHONE NUMBER			FAX NUMBER			
APPLICANT'S CURRENT ADDRESS (PLEASE WRITE BELOW)			PHONE NUMBER			
APPLICANT'S SIGNATURE						

THIS SECTION TO BE FILLED OUT BY SHH CARE COMMITTEE

DATE RECEIVED	DATE OF REVIEW
COMMENTS:	