



# Friendship House Fayetteville Friend Resident Application

## Mission Statement

Friendship House Fayetteville works alongside young adults with intellectual and developmental disabilities and their families to provide intentional, transitional living. At its core, this faith-based community is rooted in table fellowship expressed through a daily rhythm of eating, praying and celebrating together.



## Friendship House Fayetteville Model

Each of the three homes will have two apartment suites. In each suite, three healthcare students live with one "friend resident." Friend residents are young adults with intellectual and developmental disabilities (I/DD), such as Down Syndrome or Autism. As a gateway to independent living, friend residents are expected to maintain part-time jobs or significant volunteer work and be able to take care of themselves. Healthcare students live as housemates and friends, setting positive examples and help foster the interdependence of friend residents.

[www.FriendshipHouseFayetteville.org](http://www.FriendshipHouseFayetteville.org)

910-826-4699 (Ext. 261)

# Friend Resident Admission Requirements Role & Expectations

The core members of Friendship House are the Friend Residents. Young adults with intellectual/developmental disabilities who, with the support of their families, housemates, and rehabilitation staff are prepared to maintain or seek a part-time job or significant volunteer opportunity in the community, care for themselves, be a friend to housemates, participate in the community life of Friendship House as best they can, and make an effort to develop their independent living skills. The rhythm of the community is *Eat, Pray, Celebrate*.

## Admission Requirements

- Minimum age of 21 (30-year age maximum at entry of Friendship House) 4-year maximum stay
- Guardians are responsible for monthly rent (\$450 per month, which includes utilities and not food/activities)
- Participate in minimally in biannual assessments. The Assessment of Functional Living Skills by James W. Partington by A New Leaf Therapeutic Services PLLC to assess areas of skills
- Where applicable provide legal documents of guardianship, power of attorney details, competency details and health insurance.
- Participate with family members in developing the Individual Service Plan and related goals.
- Currently hold or seek meaningful employment or significant volunteer position in the community outside of Friendship House, where appropriate with the support of certified supported employment staff.
- Able to self-medicate (signed statement from your doctor indicating you are able to self-medicate" if needed.) Updates provided within 24 hours for any new or changes in medications
- Has financial resources to sustain rent and living expenses
- Family of friend resident is available and supportive to work each month to set and assess goals and progress with Resident Director and ServiceSource staff order to graduate from Friendship House.
- Family must live in Cumberland County
- Healthcare student residents are neither qualified nor required to be caretakers of Friend Residents (i.e. medical conditions or services that require onsite care-taking).
- Participate to the best of your ability in the rhythm of the FH community of *Eat, Pray, Celebrate* by coming to together in daily prayer and weekly dinner fellowship with housemates (minimum once per week dinners)

## Role and Expectations:

- Be a friend
- Applicant expresses the desire to live interdependently and participate in the community life and prayer of Friendship House to the extent that they are able.
- Each month, the Friend Resident, and their families, along with the Residency Director will meet to review their goals and progress.
- Utilize and maximize independent and interdependent living skills (social and soft skills)
- Develop and enhance the ability to manage time and daily routines (activities of daily living)
- Roommates are not responsible of daily meals for Friend Residents (apartments and homes will come together in fellowship at least once per week)
- Learn how to interact, share chores and responsibilities as a housemate, while understanding student resident roles and responsibilities with their school and jobs.



Friend Resident  
**Background Check Release &  
Drug Screening**

Date: \_\_\_\_\_

Please fill out the following information and release permission for Friendship House Fayetteville to run a background check. Information contained on this form is PHI/P11 and confidential. The material may be covered under The Privacy Act, 5. USC 55261 and/or the HIPPA (PL 104-191). Unlawful viewing or release may result in fines of up to \$5,000.

Full Legal Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Social Security# \_\_\_\_\_

Provide current and then most recent prior residence:

1.

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dates of Residence \_\_\_\_\_

2. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dates of Residence \_\_\_\_\_

I give permission for the office of ServiceSource as partners of Friendship House Fayetteville to use my personal information to run a background check and drug screening as a part of my application to Friendship House Fayetteville.

Signature of Friend Resident \_\_\_\_\_

Guardian or Power of Attorney Signature \_\_\_\_\_



## CODE OF ETHICS/APARTMENT RULES

1. Establishing boundaries
  - a. What household items are to be shared by all. Examples:
    - Cleaning items
    - Furniture
    - Pots, pans, kitchen items, etc.
    - Television (common living area)
  - b. Personal property are off limits to housemates: (unless person offers or permission was given)
  - c. Friends/family are allowed to spend the night occasionally
    - Overnight guests are not encouraged. Housemates are asked to notify fellow housemates and Resident Director of overnight guests. Guests are not permitted to consecutively and excessively spend the night, move belongings in, disrupt the rhythm of the community, etc. as they do not pay the rent and must respect the experience and sensitivity for Friend Residents. If this happens, Resident Director and ServiceSource will discuss and address the situation properly according to lease agreement.
    - Personal belongings should stay in the bedroom and not infiltrate the rest of the house
    - Housemates may not help themselves to other housemates food, drinks, personal items, etc.
    - All housemates need to clean up behind themselves if they make a mess or take a shower, etc. Housemates should not be expected to clean up after other housemate's guest(s).
2. If all housemates are planning meals together, then all housemates should split grocery expenses for those meals or for shared items such as eggs, milk, condiments and bread. (This works well to eliminate waste and using up treasured real estate in the refrigerator).
5. Do not go into housemate's room for any reason unless housemate asks you to do so.
6. It is suggested to keep your bedroom door closed when you are not at home.
  - a. This makes it easier for your housemates when guests are over, so they don't have to worry about them going into your room.
  - b. This keeps boundaries established that your room is not a free for all.
7. Clean up after yourself in shared spaces. (bathroom, kitchen/appliances, den, etc.)
8. Designate and agree upon chores and responsibilities among apartment housemates

9. Respect each other's privacy and establish guidelines for quiet hours etc. (adhering to the city noise ordinance)

10. Tell your housemate where you are going and when to expect you back or leave a note. This is just to be courteous. Make sure you exchange phone numbers with your roommate and hang emergency numbers on the refrigerator. Residents/Housemates are welcome to travel home, out of town, etc.

11. Alcohol is permitted but must be used in a respectful manner and not excessively. It must not be left in the kitchen or communal living space for others to have access. Alcohol consumption is NOT allowed for anyone under 21 years of age. Friend Residents are not permitted to consume alcohol without the permission of their guardian. If alcohol becomes used in a manner of which the other housemates, Residency Director or ServiceSource staff do not feel comfortable with, could lead to a ban on alcohol within the apartment. Any code of ethics, disrespect and boundaries broken may result in being removed from Friendship House.

12. Pets are NOT permitted (exceptions to the NC ADA Service Animal Law)

13. Firearms and any form of weapons (all guns, knives and possible items that may cause harm) are NOT permitted by housemates or guests.

13. Remember to be honest, respectful and responsible and participate in having the desire to maximize interdependent living skills, social skills and participating in the rhythm of the Friendship House Fayetteville community.

No illegal drugs or drug use will be tolerated

**I hereby acknowledge and agree to the roles, expectations and code of ethics stated for Friend Residents at Friendship House Fayetteville. As a Friend Resident I am responsible for adhering to the stated requirements, I understand it may will result up to potential removal of the Friend Resident from Friendship House Fayetteville.**

**Friend Resident Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Friend Resident Printed Name** \_\_\_\_\_

**Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guardian Printed Name** \_\_\_\_\_



## Friend Resident Assessment Information

Date \_\_\_\_\_

Person completing application \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

**Information contained on this form is PHI/P11 and confidential. The material may be covered under The Privacy Act, 5. USC 55261 and/or the HIPPA (PL 104-191). Unlawful viewing or release may result in fines of up to \$5,000.**

### APPLICANT INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female (check box)

Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_

Categories that best describes you  White  Hispanic/Latino/Spanish  Black/African American  Asian  American Indian/Alaska Native  Middle Eastern/North American  Native Hawaiian/Other Pacific Islander  Other race/ethnicity or origin

### MEDICAL

#### PRIMARY HEALTH INSURANCE (copy of medical card is required)

Primary Health Insurance Provider Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy holder SS# \_\_\_\_\_

Policy# \_\_\_\_\_ Relationship to Friend Resident \_\_\_\_\_

Medicaid # \_\_\_\_\_ Medicare # \_\_\_\_\_

Medical Diagnosis \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

**GUARDIAN & CONTACT INFORMATION**

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Father's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Designated Representative \_\_\_\_\_ Phone \_\_\_\_\_

Power of Attorney \_\_\_\_\_ Phone \_\_\_\_\_

FIA Case Worker \_\_\_\_\_ Phone \_\_\_\_\_

Community Mental Health Worker \_\_\_\_\_ Phone \_\_\_\_\_

Place of Work \_\_\_\_\_ City \_\_\_\_\_

Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Place of School \_\_\_\_\_ Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Other Contacts (i.e. podiatrist, psychologist)

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact (other than guardian/parents) \_\_\_\_\_ Phone \_\_\_\_\_

Can you administer medication independently Yes  No

**MEDICATIONS**

(Please list all Prescription drugs and Over the Counter drugs currently taking)

Prescription/OTC	Medication	Dosage	Reason for Medication


**Please provide most recent shot records for Friend Resident with application**

**ALLERGIES**

Do you have allergies (food, medications, animals, etc.)? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please list below.

What are you allergic to?	Type (food/Medications)	Reaction

**PREVIOUS SURGERIES; MEDICAL CONDITIONS - please check yes or no**

- |                          |                          |                            |                          |                          |  |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--|
| Yes                      | No                       |                            | Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart/Vascular Condition   | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease/Hepatitis                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Lung Conditions     | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                   | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever            | <input type="checkbox"/> | <input type="checkbox"/> | Hearing/Vision Impairment                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                     | <input type="checkbox"/> | <input type="checkbox"/> | Psychological Condition                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding/Clotting Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal Condition                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Epilepsy       | <input type="checkbox"/> | <input type="checkbox"/> | Skin Conditions                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological Condition     | <input type="checkbox"/> | <input type="checkbox"/> | Handicap/Disabilities (not already listed) |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease             | <input type="checkbox"/> | <input type="checkbox"/> | Assistive Devices                          |
|                          |                          |                            | <input type="checkbox"/> | <input type="checkbox"/> | Other                                      |





If yes to any above, please explain

\_\_\_\_\_

\_\_\_\_\_ Do you live with a pet? \_\_\_\_\_

## Friend Resident Assessment Reference Information

Applicant Name \_\_\_\_\_

Date \_\_\_\_\_

Please provide the names, addresses, phone numbers and relationship to applicant of  
the three persons you are asking to provide letters of reference.  
(Not related to the applicant)

Name \_\_\_\_\_

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

Address \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

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

Address \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

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

Address \_\_\_\_\_

Phone \_\_\_\_\_

Your signatures below will release the Friendship House Assessment Team and the above listed Contact Persons to openly confer and share the information regarding the above applicant.

Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Applicant \_\_\_\_\_ Date \_\_\_\_\_

**Please return to:** ServiceSource  
600 Ames St. Fayetteville, NC 28301  
[FriendshipHouse@servicesource.org](mailto:FriendshipHouse@servicesource.org)

Upon the review of the application, the selected Friend Resident and guardian will be notified for a face to face interview. If applicant is selected to be a Friend Resident, a formal contract and lease must be signed.

CONFIDENTIAL