

Cedar Lake Enrichment Center Adult Day Program Application for Enrollment

APPLICANT INFORMATION:

Date of application: _____

Full Name of Applicant: _____

Social Security #: _____

Date of Birth: _____

Current Address: _____

Name of person completing form: _____

Address: _____

Phone: (DAY): _____ (EVENING): _____

Relationship to Applicant: _____

Does Applicant have a Legal Guardian? YES ___ NO

*******GUARDIAN MUST SIGN THE APPLICATION***** SUBMIT COPY OF COURT ORDER*******

Name: _____

Address: _____

City: _____

Phone: _____ Relationship: _____

Co-Guardian/Stand-by Guardian: _____

Date of Adjudication: _____ County/State: _____

Person to contact in the event of an emergency:

Relationship: _____

Phone Number(s): _____

FAMILY INFORMATION:

Father: _____

Address: _____

Phone: _____ Date of Birth: _____

Occupation: _____

(If deceased, give date of death): _____

Mother: _____

Address: _____

Phone: _____ Date of Birth: _____

Occupation: _____

(If deceased, give date of death:)

Brothers/Sisters:

NAME	Date of birth:	At Home?
_____	_____	_____
_____	_____	_____

Names & ages of others living with the applicant: _____

Religious preference: _____

EDUCATIONAL BACKGROUND:

<u>School Attended:</u>	<u>Year(s) Attended:</u>	<u>Address:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other community involvement (i.e. club memberships):

ADULT DAY PROGRAM SERVICES:

ARE YOU INTERESTED IN RECEIVING (PLEASE CHECK ONE):

- 1) **FULL TIME-** (5 DAYS PER WEEK, 8:30 AM TO 4:00 PM)
- 2) **PART TIME-** (PLEASE SELECT ONE OF THE FOLLOWING:)
 - 5 DAYS PER WEEK- 8:30 AM TO 11:30 AM
 - 5 DAYS PER WEEK- 1:00 PM TO 4:00 PM
 - 3 DAYS PER WEEK- 8:30 AM TO 4:00 PM
 - OTHER- PLEASE SPECIFY:

Is your applicant funded through any of the following sources:

SCL Waiver HCB Waiver ABI Waiver Private Pay

State General Funding Other Payment Resources

APPLICANT'S PHYSICAL/MEDICAL INFORMATION:

Height:_____ Weight:_____

When diagnosis of Mental Retardation was first made?_____

Other developmental disorder diagnosis (Autism, Down Syndrome, etc.)_____

Applicant's level of Mental Retardation: (Mild, Moderate, Severe, Profound)-

Borderline:	I.Q. Range= 70-90
Mild:	I.Q. Range= 55-70
Moderate:	I.Q. Range= 40-55
Severe:	I.Q. Range= 25-40
Profound:	I.Q. Range= less than 25

Psychiatric Diagnosis (if applicable):

__Cause of disability:_____

Does applicant have a history of seizures?_____

Date of first seizure?_____ Frequency of seizures:_____

Type of seizures?_____

MEDICATIONS:

Name:	Dosage:	How often?	For what?	How Long?
1 _____				
2 _____				
3 _____				
4 _____				

Allergies (medicine, food or other):_____

Physician Name:_____

Address:_____ Phone:_____ Fax:_____

Pharmacy Name:_____

Phone:_____ Fax:_____

Date of last visit: _____

Date of last complete physical exam: _____

Are immunizations up to date? _____

Medical Hospitalizations\ Facility Admissions: _____

Date of last TB Skin Test (PPD) _____ *(certificate required prior to enrollment)*

List childhood illnesses/diseases & age or date they occurred: _____

Any past serious medical conditions, accidents or injuries & dates: _____

Current health problems/diagnosis/treatment: _____

Place "X" beside any that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Environmental Allergies |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Muscle, Bone, Joint | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |

If the applicant is non-verbal, how are you able to determine that they are not feeling well?

Please describe any of the above if necessary: _____

Adaptive Devices:

(Place an "X" by all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Dental Splint | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Motorized Wheelchair | <input type="checkbox"/> Cane | <input type="checkbox"/> Adaptive Plate |
| <input type="checkbox"/> Hand Splint | <input type="checkbox"/> Crutches | <input type="checkbox"/> Leg Braces |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Adaptive Utensils | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Adaptive Plate | |

___ Helmet

___ Hearing Aid

___ Shower Chair

___ Communication Device

Briefly describe likes and dislikes of the applicant:

COMMUNICATION MODALITY:

___ Verbal-uses sentences

___ Non-Verbal but understands

___ Verbal-uses one word utterances

___ Non-Verbal-uses sign language and/or gestures to communicate with others

___ Does not appear to understand what is being said to him/her

Please give brief details about applicant's communication and comprehension skills:

Disruptive Behaviors (please "X" all that apply):

___ Violent/Destructive Behavior

___ Antisocial Behavior (teasing, bossing)

___ Rebellious (resists rules/instructions)

___ Untrustworthy (lies, cheats, steals)

___ Withdrawn (shy, keeps to self)

___ Stereotyped behavior (pacing, rocking, repeated movement)

___ Self-abusive (slap, hit, pinch, bite)

___ Hyperactivity

___ Inappropriate Sexual behavior

___ Emotional Instability (mood swings)

___ Incontinent of bowel and/or bladder

(Frequency:_____)

___ Eating Disorder

State how those things indicated affect the applicant's daily life: _____

_____ List any emotional/psychological issues that may affect the applicant's life:

SKILLS CHECKLIST (D if dependent on others, N if needs assistance, and I if independent).

- | | |
|---------------------------------|------------------------------------|
| ___ Feeds self | ___ Toilets Independently * |
| ___ Dresses self | ___ Bathes Self |
| ___ Cooks | ___ Crosses street |
| ___ Sets table | ___ Maintains eye contact |
| ___ Washes dishes | ___ Makes wants/needs known |
| ___ Sweeps | ___ Cares for possessions |
| ___ Turns TV on/off | ___ Handles change (coins & bills) |
| ___ Makes a sandwich | ___ Plans social activities |
| ___ Orders food in restaurants | ___ Manages money (over \$5) |
| ___ Follows 2 step instructions | ___ Respects others belongings |
| ___ Treadmill | ___ Stationary Bike |

Briefly describe the applicant's typical daily routine:

- **If applicant is not independent in toileting, please mark one of the following:**

___ Time toileting (taken every 2 hours or other increments of time)

___ Wears adult protective briefs

___ Other: (Please explain: _____)

Signature: _____ Date: _____

(Person completing this form)

Please send completed form to:

Cedar Lake Enrichment Center

Attn: Applicant Committee

230 Yager Avenue

LaGrange, KY 40031

502.222.0053