

CEDAR LAKE, INC. 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: _____

Phone: _____ Relationship: _____

Co-Guardian/Stand-by Guardian: _____

Date of Adjudication: _____ County/State: _____

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: _____

Church affiliation: _____

Level of involvement: _____

EDUCATIONAL BACKGROUND:

School Attended:

Year(s) Attended:

Address:

Work experience paid: _____

Volunteer jobs: _____

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

APPLICANT'S PHYSICAL/MEDICAL INFORMATION:

Height: _____ Weight: _____

When was diagnosis of Mental Retardation made? _____

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

Person who diagnosed: _____

Cause of disability: _____

Does applicant have a history of seizures? _____

Date of first seizure? _____

Frequency of seizures: _____ Type of seizures? _____

COMMUNICATION MODALITY:

- _____ Verbal-uses sentences
- _____ Non-Verbal but understands
- _____ Verbal-uses one word utterances
- _____ Does not understand what is said
- _____ Non-Verbal-uses sign language

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

MEDICATIONS:

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

Allergies (medicine, food or other): _____

Physician Name: _____

Address: _____ Phone: _____

Date of last visit: _____

Date of last complete physical exam: _____

Are immunizations up to date? _____

Medical \ Psychiatric \ Residential Admissions:

<u>Hospital\Facility</u>	<u>Reason</u>	<u>Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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"/> Respiratory problems | |
| <input type="checkbox"/> Muscle, Bone, Joint Problems | |

Please describe any of the above if necessary: _____

SUPPORT THERAPIES:

(If currently receiving, mark "C"; if received in the past mark "X")

(Submit assessment with packet)

Occupational Therapy-- Therapist

Name & Address: _____

Phone: _____

Physical Therapy--Therapist

Name & Address: _____

Phone: _____

Speech Therapy--Therapist

Name & Address: _____

Phone: _____

Therapy for Mental Illness/Behavior Problems--

Name and Address: _____

Phone: _____

Adaptive Devices:

(Place an "X" by all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> Dental Splint |
| <input type="checkbox"/> Motorized Wheelchair | <input type="checkbox"/> Cane | <input type="checkbox"/> Shower Chair |
| <input type="checkbox"/> Hand Splint | <input type="checkbox"/> Bed Rails | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Adaptive Utensils | <input type="checkbox"/> Hoyer Lift |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Dentures | <input type="checkbox"/> Adaptive Plate |
| <input type="checkbox"/> Helmet | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Leg Braces |

Other: _____

DENTAL INFORMATION:

Dentist: _____ Phone: _____

Address: _____

Date of last visit: _____

Condition of teeth and gums: _____

PSYCHOLOGICAL INFORMATION:

Last psychological testing: _____

(Send copy including raw data if possible)

Testing completed by: _____

Psychiatric diagnosis received from testing: _____

List any emotional/psychological problems with dates of occurrence: _____

Hospitalizations for these occurrences (please include dates): _____

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)
- Sleep problems (insomnia, night waking, etc.)

- ___ Stereotyped behavior (pacing, rocking, repeated movement)
- ___ Self-abusive (slap, hit, pinch, bite)
- ___ Hyperactivity
- ___ Inappropriate Sexual behavior
- ___ Emotional Instability (mood swings)

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

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

- | | |
|---|------------------------------|
| ___ Feeds self | ___ Toilets Independently |
| ___ Dresses self | ___ Makes appointments |
| ___ Bathes Self | ___ Public transportation |
| ___ Sorts laundry | ___ Cocks |
| ___ Does laundry | ___ Crosses street |
| ___ Sets table | ___ Maintains eye contact |
| ___ Washes dishes | ___ Makes wants/needs known |
| ___ Sweeps | ___ Cares for possessions |
| ___ Turns TV on/off | ___ Makes bed |
| ___ Handles change (coins & bills) | ___ Makes a sandwich |
| ___ Orders food in restaurants | ___ Plans social activities |
| ___ Follows 2 step commands | ___ Manages money (over \$5) |
| ___ Respects others belongings | ___ Shops for groceries |
| ___ Can access/ride public transportation | ___ Can reside with others |

Safety Skills

- | | |
|--------------------------------------|---|
| ___ Able to call 9-1-1 | ___ Able to recognize danger |
| ___ Knowledgeable of basic first aid | ___ Able to exit independently if in danger |

FINANCIAL INFORMATION: ("X" all that apply):

- | | |
|--|--------------------------|
| ___ SCL waiver | ___ HCB waiver |
| ___ KY Medical Assistance Card | ___ Social Security |
| ___ SSI | ___ Medicare |
| ___ Railroad Retirement | ___ Teacher's Retirement |
| ___ Veteran's Benefits | |
| ___ Health Insurance (name of company) | _____ |

STATEMENT OF NEED/REASON FOR APPLICATION:

Is applicant on any other waiting list(s) for community or residential services? ___Yes ___No

If so please list: _____

Are there any family or community supports in place at this time?

