Wendell Foster's

A

Campus for Developmental Disabilities
ICF/IID
APPLICATION FOR ADMISSION

Please do not leave blanks (If not applicable indicate N/A)

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 APPLICATION*****SUBMIT COPY OF COURT ORDER*****

Guardian: _____

Address: _____

_____

Phone: _____ Relationship: _____

E-mail (optional) _____

Co-Guardian/Stand-by Guardian: _____

Address: _____

_____

Phone: _____ Relationship: _____

Date of Adjudication: _____ County/State: _____

E-mail (optional) _____

FAMILY INFORMATION:

Father: (first, middle, last) _____

Address: _____

Phone: _____ Date of Birth: _____

Place of birth: _____

Place of Employment: _____Phone: _____

Social Security #: _____

(If deceased, give date of death): _____ Marital Status: _____

Mother: (first, middle, maiden, married) _____

Address: _____

Phone: _____ Date of Birth: _____

Place of birth: _____

Place of Employment: _____ Phone: _____

Social Security #: _____

(If deceased, give date of death): _____ Marital Status: _____

Brothers/Sisters:

Name Date of Birth At Home?

_____

_____

_____

Names and ages of others living with the applicant: _____

_____

_____

Family Medical History:

	Yes	No	Member of family
Diabetes	☐	☐	_____
Tuberculosis	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Glaucoma	☐	☐	_____
Other	☐	☐	_____

Birth/Early Development:

Mother's health during pregnancy of applicant: _____

Length of pregnancy: _____ Length of Labor: _____

Weight gained: _____ Birth Weight: _____

Presentation: Normal ☐ Breech ☐ Caesarean ☐

Describe any unusual conditions which existed during pregnancy of the applicant (for example: RH incompatibility, hemorrhage, physical illness, accident, emotional upset, measles, x-rays, kidney infection, etc.): _____

_____

Injuries/Scars/Deformities at birth: _____

_____

_____

_____

Anesthesia used: Yes ☐ No ☐ Breathing Difficulty: Yes ☐ No ☐

Instruments used: Yes ☐ No ☐ Jaundiced: Yes ☐ No ☐

Born Blue: Yes ☐ No ☐

Hospital: _____

Doctor: _____

Type of feeding: _____

Formula: _____

Age of weaning: _____

Indicate if there were any difficulties involving:

	Age
Seizures	_____
Sucking	_____
Swallowing	_____
Transfusions	_____
Weight Loss	_____

Describe how the applicant behaved during the first few months of life:

_____

_____

As nearly as possible, please indicate when the applicant first:

	Age		Age
Held head up	_____	Said first words	_____
Sat alone	_____	Toilet trained	_____
Crawled	_____	Bowel	_____
Walked alone	_____	Bladder	_____
Babbled	_____		

Check any of the following which occurred frequently during his/her development:

☐ Combative to others ☐ Sleeplessness ☐ Thumb sucking

☐ Destructiveness ☐ Strong fears ☐ other: _____

☐ Fainting ☐ Temper tantrums _____

APPLICANT'S PHYSICAL/MEDICAL INFORMATION:

Height: _____ Weight: _____

When was the diagnosis of Intellectual Disability first made? _____

Other developmental disorder diagnosis (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? _____

Allergies (medicine, food or other): _____

_____

Physician Name: _____

Address: _____

Date of last visit: _____

Date of last complete physical exam: _____

Are immunizations up to date? _____

Medical Hospitalizations/Facility Admissions:

Hospital/Facility	**Reason**	**Date**

If additional space is needed please use reverse.

Surgical procedures: _____ If yes, list type _____

_____

_____

Does applicant have any indwelling stents, metal clips, pins, etc.: _____ If yes, what?

_____

_____

Indicate which of the following illnesses he/she has had, giving age and severity:

Mild (M), Average (A) and Severe (S) Circle one

	Age			Age	
Bronchitis	____	M☐ A☐ S☐	Mumps	____	M☐ A☐ S☐
Chicken Pox	____	M☐ A☐ S☐	Paralysis	____	M☐ A☐ S☐
Colds (frequent)	____	M☐ A☐ S☐	Pneumonia	____	M☐ A☐ S☐
Constipation	____	M☐ A☐ S☐	Rheumatic Fever	____	M☐ A☐ S☐
Diarrhea	____	M☐ A☐ S☐	Scarletina	____	M☐ A☐ S☐
Earaches (Otitis)	____	M☐ A☐ S☐	Strept Throat	____	M☐ A☐ S☐
Encephalitis	____	M☐ A☐ S☐	Tonsillitis	____	M☐ A☐ S☐
Hepatitis	____	M☐ A☐ S☐	Whooping Cough	____	M☐ A☐ S☐
Kidney infections	____	M☐ A☐ S☐	Other _____		M☐ A☐ S☐
Measles	____	M☐ A☐ S☐	_____		
Meningitis	____	M☐ A☐ S☐			

Any past serious medical conditions, accidents or injuries and date: _____

_____

_____

Place "X" beside any that apply:

☐ Diabetes ☐ Urinary Problems ☐ Bowel Problems ☐ Dental Problems

☐ Hearing Problems ☐ Vision Problems ☐ Stomach Disorder

☐ Dizziness/Fainting ☐ Frequent Colds ☐ Ear Infections

☐ Muscle, Bone, Joint Problems ☐ Heart Problems ☐ Allergies

☐ Swallowing Problems ☐ Breathing Problems

☐ Skin Problems ☐ Epilepsy

Please describe any of the above necessary: _____

_____

_____

_____

_____

_____

SUPPORT THERAPIES:

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

(Submit assessment with packet)

☐ Occupational Therapy

Provider Name & Address: _____

Phone: _____

☐ Physical Therapy

Provider Name & Address: _____

Phone: _____

☐ Speech Therapy

Provider Name & Address: _____

Phone: _____

☐ Therapy for Mental Illness/Behavior Problems

Provider Name & Address: _____

Phone: _____

Adaptive Devices:

(Place an "X" by all that apply)

☐ Manual Wheelchair	☐ Hospital Bed	☐ Dental Splint	☐ Other
☐ Motorized Wheelchair	☐ Cane	☐ Shower Chair	_____
☐ Hand Splint	☐ Bed Rails	☐ Crutches	_____

Adaptive Devices (continued):

☐ Glasses	☐ Adaptive Utensils	☐ Hoyer Lift	_____
☐ Walker	☐ Dentures	☐ Adaptive Plate	_____
☐ Helmet	☐ Hearing Aid	☐ Leg Braces	_____

Current Status:

☐ Uses words to communicate; speaks sentences

☐ Uses words to communicate; speaks one word utterances

☐ Doesn't use words to communicate; uses sign language

☐ Doesn't use words to communicate but understands

☐ Does not understand what is said

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

_____

_____

Language Spoken: _____

How does he/she communicate? _____

Voice quality normal: ☐ Yes ☐ No If no, explain: _____

Does he/she understand what is said to him/her: ☐ Yes ☐ No

Coordination: Good ☐ Fair ☐ Poor ☐

Does he/she lose balance easily? _____

_____

Hearing impairments: ☐ Yes ☐ No If yes, explain: _____

Hearing aide: ☐ Yes ☐ No

Visual impairment: ☐ Yes ☐ No

Eyeglasses: ☐ Yes ☐ No

Diet/Food & Liquid Consistency:_____

DENTAL INFORMATION:

Dentist: _____ Phone: _____

Address: _____

Date of last visit: _____

Condition of teeth and gums: _____

Dental condition: ☐ Good ☐ Fair ☐ Poor

Dental appliances: ☐ Yes ☐ No If yes, identify: _____

Religious/Church preference and level of involvement:

_____

_____

PSYCHOLOGICAL INFORMATION:

Last psychological testing: _____

Testing completed by: _____

Psychiatric diagnosis from testing: _____

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

_____

_____

BEHAVIORAL INFORMATION:

Does he/she presently:	Yes	No	If yes, describe:
Act aggressively towards others	☐	☐	_____
Cry often	☐	☐	_____
Display temper tantrum	☐	☐	_____

Have difficulty eating	☐	☐	_____
Difficulty interacting with others	☐	☐	_____
Self-abusive	☐	☐	_____
Have sleeping problems	☐	☐	_____
Violent/Destructive behavior	☐	☐	_____
Stereotyped behavior (pacing, rocking, repeated movement)	☐	☐	_____
Hyperactivity	☐	☐	_____
Inappropriate Sexual behavior	☐	☐	_____
Emotional instability	☐	☐	_____

Indicate whether he/she frequently (F), occasionally (O) or never (N) is: Check one:

	F	O	N		F	O	N
Affectionate	☐	☐	☐	Jealous	☐	☐	☐
Aggressive	☐	☐	☐	Nervous	☐	☐	☐
Dependable	☐	☐	☐	Rude	☐	☐	☐
Destructive	☐	☐	☐	Selfish	☐	☐	☐
Fearful	☐	☐	☐	Show-off	☐	☐	☐
Friendly	☐	☐	☐	Sociable	☐	☐	☐
Generous	☐	☐	☐	Sullen	☐	☐	☐

How much supervision does he/she require during waking hours? _____

_____

Does he/she exhibit any behavior problems? ____ If so, describe the behaviors and identify the situations where they occur. _____

_____

How are behavior problems handled? _____

_____

_____

Behavior medications used (past and present): _____

_____

Any psychiatric commitments: ☐ Yes ☐ No if yes, explain: _____

_____

PERSONAL LIVING SKILLS:

Toileting Habits:

Toilet trained: ☐ Yes ☐ No

How does he/she indicate the need to go to the bathroom: _____

_____

Standard toilet fixtures: ☐ Yes ☐ No If no, describe: _____

_____

Sleeping Habits:

At night, sleeps from _____PM to _____AM Average hours: _____

Any sleep disturbances (insomnia, dreams, nightmares, enuresis, etc.)? _____

_____

Leisure Time Activities:

Indicate what he/she enjoys:

☐ Adventure activities
☐ Art/music/entertainment
☐ Crafts
☐ Hobbies (collections)
☐ indoor activities
☐ outdoor activities _____
☐ social clubs (community, peer groups)
☐ sports _____

What routine activities does he/she participate: _____

_____

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

____ Feeds Self
____ Dresses self
____ Bathes self
____ Sorts laundry
____ Does laundry
____ Sets table
____ Washes dishes
____ Sweeps
____ Turns TV off
____ Drinks from a cup
____ Orders food in restaurants
____ Follows two step commands
____ Respects others belongings
____ Hair Care
____ Toilets self
____ Makes appointments
____ Public transportation
____ Cooks
____ Crosses street
____ Maintains eye contact
____ Makes wants/needs known
____ Cares for possessions
____ Makes bed
____ Makes a sandwich
____ Plans social activities
____ Manages money (over $5.00)
____ Shops for groceries
____ Dental Care

EDUCATIONAL BACKGROUND

School Attended: **Year(s) Attended:** **Address:**

_____

_____

_____

_____

Work experience paid: _____

Volunteer jobs: _____

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

_____

_____

FINANCIAL INFORMATION: ("X" all that apply)

____ Medicaid Assistance Card State___ MA#: _____

____ Medicare #: _____

____ Social Security Amount Received Monthly: $_____

____ SSI Amount Received Monthly: $_____

____ Railroad Retirement Amount Received Monthly: $_____

____ Veteran's Benefits Amount Received Monthly: $_____

____ Other Income

Description:_____ Amount Received Monthly: $_____

Description:_____ Amount Received Monthly: $_____

____ Health Insurance (Primary):

Name of company_____ Policy Holder:_____

Member ID #: _____ Group#:_____

____ Health Insurance (Secondary)

Name of company_____ Policy Holder:_____

Member ID #: _____ Group#:_____

____ Life Insurance

Name of Company_____ Policy Holder:_____

Cash Value: $_____

RESOURCES AND ASSETS

___ Checking Account Account balance: $_____

___ Savings Account Account balance: $_____

___ Trust Type:_____ Account balance: $_____

___ STABLE Account ___ ABLE Account Account balance: $_____

___ Funeral/Burial Fund

Revocable___ Irrevocable___ Account balance: $_____

___ Other Assets (vehicle, property, etc.)

Description:_____ Estimated Value: $_____

Description:_____ Estimated Value: $_____

STATEMENT OF NEED/REASON FOR APPLICATION:

Is applicant on any other waiting list(s)? ☐Yes ☐No

If so, please list:_____

_____

_____

Is there any family or outside assistance given in the daily care of he applicant at this time?

_____

_____

Please state the reason(s) you are applying for admission, your hopes for the applicant's future.

_____

_____

_____

_____

_____

All information pertaining to the Wendell Foster's Campus admission application and other documents are accurate and true to the best of my knowledge. I understand that any falsification of these documents could result in discharge of the above named individual

_____ _____

Applicant/Parent/Guardian Date

_____ _____

Witness Date