APPLICATION OF ADMISSION OF SERVICES

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| **APPLICATION INFORMATION: *PLEASE PRINT*** | **Date of Admission:** |  |

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| **Applicant Name:** |  | **Nickname:** |  |

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| **Present Address:** |  | **Zip Code:** |  |

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| --- | --- | --- | --- |
| **Home Phone:** |  | **Emergency Phone:** |  |

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| --- | --- | --- | --- | --- | --- |
| **Place of Birth:** |  | **Date of Birth:** |  | **SS#:** |  |

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| **Hair:** |  | **Eyes:** |  | **Height:** |  | **Weight:** |  | **Sex:** |  | **Race:**  |

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| **Marital Status:** |  | **Applicant’s Spouse Name:** |  |

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| **Spouse’s Address:** |  | **Zip Code:** |  |

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| **Languages Spoken by Applicant:** |  |

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| --- | --- |
| **Languages Understood by Applicant:** |  |

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| --- | --- |
| **Criminal Justice Status:** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Financial Resources:** |  | SSI |  | SSDI |  | Railroad |  | Black Lung Compensation |

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|  |  | Bank Accounts |  | Trusts |  | Stock/Bond |  | Other |

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| --- | --- |
| **Name of Parent:** |  |

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| --- | --- | --- | --- |
| **Address:** |  | **Zip Code:** |  |

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| **Home Phone:** |  |  Business Phone: |  |

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| **Please check appropriate area of residence of person legally responsible for Applicant:** |

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|  | **Norfolk** |  |  | **Portsmouth** |  |  | **Virginia Beach** |

|  |  |  |  |  |  |  |  |
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|  | **Chesapeake** |  |  | **Newport News** |  |  | **Hampton** |

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|  | **Williamsburg** |  |  | **Suffolk** |  |  | **Other** |

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| **Referral Source & Name:** |  |

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| --- | --- | --- | --- |
| **Address:** |  | **Zip Code:** |  |

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| **Phone:** |  |

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| **Reason for Referral:** |  |
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| EDUCATIONAL HISTORY |

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| --- | --- | --- | --- |
| **Age Began School:**  |  | **Years Completed:** |  |

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| --- | --- |
| **Schools Attended:** |  |
| **Name of School(s)** |  | **Location of School(s)** |  | **Dates Attended** |
|  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Special Education:** |  | **Yes:** |  |  | **No:** |  |  | **Grade level:** |  |

|  |
| --- |
| **VOCATIONAL TRAINING HISTORY:** |

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| --- | --- | --- | --- | --- |
| **Training Program** |  | **Name and Location** |  | **Dates of Training** |
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| **EMPLOYMENT HISTORY:** |

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| --- | --- | --- | --- | --- | --- | --- |
| **Job Title & Salary** |  | **Employer and Location** |  | **Length of Employment** |  | **Reason for Leaving** |
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| **INSTITUTIONALIZATIONS/HOSPITALIZATIONS:** |

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| --- | --- | --- | --- | --- |
| **Institution and Location** |  | **Dates of Admission(s) & Discharge(s)** |  | **Reason for Admission** |
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| **PREVIOUS SERVICES RENDERED:** |

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| **Agency Name** |  | **Address** |  | **Contact person** |  | **Dates** |
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| **FAMILY INFORMATION:** |

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| **Father’s Name:**  |  | **Birth date:** |  |

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| --- | --- | --- | --- |
| **Address:** |  | **Phone:** |  |

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| --- | --- |
| **Place of Employment:** |  |

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| --- | --- | --- | --- |
| **Business Phone:** |  | **Education (Years):** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Mother’s Name:** |  | **Birth date:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Address:** |  | **Phone:** |  |

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| --- | --- |
| **Place of Employment:** |  |

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| --- | --- | --- | --- |
| **Business Phone:** |  | **Education (Years):** |  |

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| **Medical Insurance/Policy Covering Applicant (Company/Number):** |  |

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| **Medicaid #:** |  | **Other #:** |  |

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| All Brothers and Sisters. List in order of birth including the Applicant: |

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| **Name** |  | **Relationship to Applicant** |  | **Birth date:** |  | **Living in Household****(Yes or No)** |
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| **Other persons living in the household:** |

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| **Name** |  | **Relationship to Applicant** |  | **Birth date:** |
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| **What Services are being requested at the present time:** |

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| **x** | **Sponsored Residential Services** |  | **OTHER** |  |  |

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| List applicant’s areas of needs for support, training, supervision and assistance |

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|  | **Independent/Living/Self Help** |  |  | **Community Integration** |  |  | **Environmental**  |
|  | **Behavioral Management** |  |  | **Communication** |  |  | **Gross/Fine Motor** |
|  | **Transportation** |  |  | **Socialization** |  |  | **Health Care / Medical** |
|  | **Nutritional** |  |  | **Spiritual** |  |  | **Academic** |
|  | **Informed Choices** |  |  | **Life’s Aspirations** |  |  | **OT / PT** |

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| **APPLICANT’S PRESENT NEEDS:**  |

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| **Please describe Applicant’s present difficulties:** |

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| **A. Psychiatric:** |  |
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| **B. Medical Problems:** |  |
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| **C. Medical Care History** |  |
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| **Does the Applicant have allergies? drew had surgery to correct Scoliosis.sability, Autism adn**  |

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|  | **Aspirin** |  |  | **Penicillin** |  |  | **Sulfa** |
|  | **Other Medications (Please list)** |  |  | **Food** |  |  | **Other (Please specify)** |

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| **Does Applicant use the following:** |
| **Eye Glasses** |  | Yes |  |  | **No** |  |  | **Sometimes** |  |  |
| **Contact lenses** |  | **Yes** |  |  | **No** |  |  | **Sometimes** |  |  |
| **Prostheses** |  | Yes |  |  | **No** |  |  | **Sometimes** |  |  |
| **Hearing Aid** |  | **Yes** |  |  | **No** |  |  | **Sometimes** |  |  |
| **Braces** |  | Yes |  |  | **No** |  |  | **Sometimes** |  |  |
| **Wheelchair** |  | **Yes** |  |  | **No** |  |  | **Sometimes** |  |  |
| **Crutches** |  | Yes |  |  | **No** |  |  | **Sometimes** |  |  |
| **Walker** |  | Yes |  |  | **No** |  |  | **Sometimes** |  |  |
| **Helmet** |  | **Yes** |  |  | **No** |  |  | **Sometimes** |  |  |
| **Assistive Technology** |  | Yes |  |  | **No** |  |  | **Sometimes** |  |  |
| **Specialized Transportation** |  | **Yes** |  |  | **No** |  |  | **Sometimes** |  |  |

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| **Does the Applicant have a history of diabetes?** |  |  | **Yes** |  | **No** |

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| **Does the Applicant have a history of seizures?** |  |  | **Yes** |  | **No** |

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| **Describe types of seizures:** |  |
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| **Contributing factors to seizure activity (i.e., flashing lights, overheating, agitation. etc.);** |
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| **Date of Seizure Onset:** |  |

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| **Number of seizures per month during the last three months:**  |  |

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| **How are the seizures managed?** |  |
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| Current medical/physical conditions now being treated. |  | Treating Physician |  | Phone # |
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