APPLICATION FOR ADMISSION

DATE___ ___ / ___ ___ / ___ ___ ___ ___

Applicant:

Full Name (nickname in parenthesis)

_____(_____)

Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___ US Citizen: Yes ___ No ____

Place of birth (city, state)_____

IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ (IL Medicaid, if applicable)

SS # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Religious preference_____ Active: Yes ___ No ___

Sex: Male ___ Female ___

Race_____ Hair color_____

Eye color_____ Height_____ Weight_____

Identifying marks _____

Language spoken/understood_____

If the applicant is not living with parents or guardian, please give name and address where he/she is currently residing:

Name_____

Contact Person_____Title_____

Address_____

_____

Phone number (___ ___ ___)___ ___ ___-___ ___ ___ ___

Applicant's Legal Guardian (Please submit a copy of Court Order)

Name_____

Address_____

Phone Numbers Home (___ ___ ___)___ ___ ___-___ ___ ___ ___

Work (___ ___ ___)___ ___ ___-___ ___ ___ ___

Cell (___ ___ ___)___ ___ ___-___ ___ ___ ___

E-mail Address _____

If limited, does guardian have power to make residential placement? Yes ___ No ___

Is the appointed Guardian of Person, Estate, Both?_____

Date Appointed Legal Guardian ___ ___ / ___ ___ / ___ ___ ___ ___

Relationship to applicant_____

Health Care Surrogate: (A Health Care Surrogate may be appointed to make medical decisions for persons if they should lose their decisional capacity. The Health Care Surrogate will only be called upon if there is no legal guardian and if there is no Medical Power of Attorney.)

Name_____

Address_____

Phone Numbers Home (___ ___ ___)___ ___ ___-___ ___ ___ ___

Work (___ ___ ___)___ ___ ___-___ ___ ___ ___

Cell (___ ___ ___)___ ___ ___-___ ___ ___ ___

E-mail Address _____

Relationship to applicant_____

Family Information:

Father

Name _____

Address _____

Phone Numbers Home (___ ___ ___)___ ___ ___-___ ___ ___ ___

Work (___ ___ ___)___ ___ ___-___ ___ ___ ___

Cell (___ ___ ___)___ ___ ___-___ ___ ___ ___

E-mail Address _____

Occupation _____Length of employment _____

Employer_____

Employer's address _____

Does your employer have a matching gifts program for charity? Yes ___ No ___
Would you like more information? Yes ___ No ___

Date of birth ___ ___ / ___ ___ / ___ ___ ___ ___

Date of death (if applicable) ___ ___ / ___ ___ / ___ ___ ___ ___

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Mother

Name _____

Address _____

Phone Numbers Home (___ ___ ___)___ ___ ___-___ ___ ___ ___

Work (___ ___ ___)___ ___ ___-___ ___ ___ ___

Cell (___ ___ ___)___ ___ ___-___ ___ ___ ___

E-mail Address _____

Occupation _____Length of employment _____

Employer_____

Employer's address _____

Does your employer have a matching gifts program for charity? Yes ___ No ___
Would you like more information? Yes ___ No ___

Date of birth ___ ___ / ___ ___ / ___ ___ ___ ___

Date of death (if applicable) ___ ___ / ___ ___ / ___ ___ ___ ___

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Parent's marital status_____

Siblings (if any) in birth order

Name	Birthday	Deceased? (date)

1._____

2._____

3._____

4._____

5._____

Important Relative/Friend

Name_____

Address_____

Phone Numbers Home (___ ___ ___)___ ___ ___-___ ___ ___ ___

Work (___ ___ ___)___ ___ ___-___ ___ ___ ___

Cell (___ ___ ___)___ ___ ___-___ ___ ___ ___

E-mail Address _____

Relationship to applicant_____

Emergency Information (persons to contact in the event of an emergency if parent/guardian is unavailable):

1) Name _____

Address_____

Phone Numbers Home (___ ___ ___)___ ___ ___-___ ___ ___ ___

Work (___ ___ ___)___ ___ ___-___ ___ ___ ___

Cell (___ ___ ___)___ ___ ___-___ ___ ___ ___

E-mail Address _____

Relationship to applicant_____

2) Name_____

Address_____

Phone Numbers Home (___ ___ ___)___ ___ ___-___ ___ ___ ___

Work (___ ___ ___)___ ___ ___-___ ___ ___ ___

Cell (___ ___ ___)___ ___ ___-___ ___ ___ ___

E-mail Address _____

Relationship to applicant_____

Miscellaneous

Please provide us with information that will help our teams give the applicant the best living and working environments possible.

What are the applicant's goals for their future?
What do you desire for the applicant's future?
Examples: Learning specific new skills, social activities, etc.

_____

_____

_____

_____

_____

_____

Reason for applying for admission to Beverly Farm:_____

_____

_____

_____

_____

_____

How did you hear about Beverly Farm?_____

_____

_____

_____

_____

_____

Financial Data

If private pay, to whom should any charges be billed?

_____

Applicant's Sources of Income (please check all that apply)

___ Social Security ___ Medicare ___ Medicaid

___ Veteran's Benefits ___ Railroad ___ Other _____

Financial references including bank (identify each by name and address):

_____

_____

_____

Name and address of family attorney (if applicable):

_____

_____

Have you written your will? Yes ___ No ___

Does it contain a Special Needs Trust for your loved one? Yes ___ No ___

Would you like information about Special Needs Trusts? Yes ___ No ___

Contacts for the will and/or trust: This may be an attorney, trustee, financial advisor, or family member. Bank/Trust or Company/Trustees who are controlling the Trust (if applicable):

_____

_____

Does the applicant have pre-arranged Burial Plans? ☐ Yes ☐ No If so, please provide us with the information.

_____

INSURANCE QUESTIONAIRE

BEVERLY FARM FOUNDATION

Name of Applicant _____

Birthdate ___ ___ / ___ ___ / ___ ___ ___ ___

Original Medicare ☐ yes ☐ no Card #: _____
(Please include Medicare card)

or

Medicare Advantage Plan ☐ yes ☐ no Name of Ins. Co. _____
(Please include plan card)

Card #: _____

Medicare D Prescription Plan ☐ yes ☐ no Name of Ins. Co. _____
(Please include Med D card)

Card #: _____

Medicaid ☐ yes ☐ no Card number:_____
(Please include Medicaid card)

State Issued by:_____
(ex: IL, KY, MO)

Commercial Insurance ☐ yes ☐ no
(Please include Insurance Card)

Name of Insurance _____

Subscriber's Name _____

Group Name _____

Group Number _____

Identification Number _____

Send Claims to: _____

_____

Is the applicant receiving SSI? yes no _____
If yes, what date was SSI awarded?

_____

If yes, submit copy of award letter
with application.

Person completing application:

Name_____

Relationship to applicant_____

We/I the undersigned to do hereby acknowledge that we/I have read and fully understand this “Application for Admission” and we/I have truthfully answered the questions to the best of our/my knowledge and ability.

In those areas in which we/I have not yet made appropriate plans for the future care of the applicant, we/I will proceed in doing so, as quickly and as completely as is practicable.

If applicant is a ward of co-guardians, both must sign the application.
If applicant is under 18, both parents (or guardians) must sign the application.

Signed_____Date:_____

Relationship to applicant_____

Signed_____Date:_____

Relationship to applicant_____

Birth & Early Development

History of Pregnancy

Age of mother at birth_____ What number pregnancy was this? _____

Total number of pregnancies:_____ Any miscarriages? ☐ Yes ☐ No

Any stillbirths? ☐ Yes ☐ No Number of living children_____

Any illnesses during the pregnancy? ☐ Yes ☐ No

Explain_____

_____

_____

_____

Any drugs taken during the pregnancy? ☐ Yes ☐ No

Explain_____

_____

_____

Birth History

Birth weight_____ Birth length_____ Length of labor? _____

Please check all that apply.

☐ Premature	☐ Transfusions	☐ Jaundiced
☐ Late Birth	☐ Infection	☐ Paralyzed
☐ Needed Oxygen	☐ Bleeding	☐ Cesarean
☐ Needed Resuscitation	☐ High Squeaky cry	☐ Forceps used
☐ Convulsion after Birth	☐ Normal cry	☐ Rash
☐ Blood Incompatibility	☐ Induced delivery by drugs	

Was delivery normal? ☐ Yes ☐ No

If not, why? _____

_____

Growth & Development History

Please give age in months or years.

Held up head_____	Crawled_____	Dressed self_____
Vocalization _____	Smiled _____	Pulled up_____
Toilet trained_____	Words _____	Sat alone _____
Walked alone_____	Rode Tricycle _____	Phrases _____

Diagnosis

What was the individual's age when their disability was first noticed? _____

What was the cause of the applicant's disability? _____

_____

_____

What was the original diagnosis?_____

When was the first diagnosis made? _____

Where was the diagnosis made? (hospital, city, state)_____

_____

Who made the diagnosis? _____

Residential/Educational/Vocational

Schools attended:

Name	Dates	Location

Residential Placements:

Name	Dates	Location

Vocational Training:

Name	Dates	Location

What would you desire the future to be like for the applicant at Beverly Farm?

_____

_____

_____

_____

FAMILY HISTORY

Please describe some of the applicant's family history. (This can include such information as family's involvement, support systems, home environment, frequent relocations, some accomplishments of individual, siblings, parents, etc.)

Medical History

Surgery, Hospitalization, Blood Transfusions

Date	Reason(s)

Current Medications (prescription, over the counter, vitamins)

Name	Dosage	Reason	Effective?

Previous Medications

Name	Dosage	Reason	Effective?

Immunization/ Health Please write the Dates in the blank provided

_____ DPT/DT Series (Tetanus/Diphtheria) _____ Flu Vaccine

_____ Tuberculosis Skin Test _____ Polio Series

_____ MMR (Measles/Mumps/Rubella) _____ HIV Test

_____ Pneumonia Vaccine _____ Other

_____ Hepatitis B Vaccine

If the applicant has seizures, what type are they? _____

Are they controlled by medication? Yes ___ No ___

Does the applicant have any allergies? Yes ___ No ___

If so, what are they? _____

How are these allergies best treated? _____

Vision (check all that apply)

☐ Functional ☐ Impaired ☐ Blind
☐ Wears glasses ☐ Has glasses but does not wear

Comments:_____

Hearing (check all that apply)

☐ Functional ☐ Impaired ☐ Deaf
☐ Wears hearing aid ☐ Has hearing aid but does not wear
☐ Uses sign language ☐ Reads lips

Comments:_____

Sleeping Habits

Average hours a night _____

Nightmares? ☐ Yes ☐ No
Sleepwalker? ☐ Yes ☐ No
Talks in Sleep? ☐ Yes ☐ No
Wets bed? ☐ Yes ☐ No

Comments:_____

Has the applicant ever had difficulty with the following?
Please check all that apply.

	When?		When?
☐ Head injury	_____	☐ Eyes or vision	_____
☐ Ear infection	_____	☐ Nose	_____
☐ Throat	_____	☐ Heart/heart murmurs	_____
☐ Lungs	_____	☐ Intestines	_____
☐ Urine infections	_____	☐ Skin	_____
☐ Arthritis	_____	☐ Seizures	_____
☐ Bed wetting	_____	☐ Difficulty sleeping	_____
☐ Measles	_____	☐ Allergies to food	_____
☐ Chicken Pox	_____	☐ Allergies to medication	_____
☐ Whooping Cough	_____	☐ Other allergies	_____
☐ Kidney infection	_____	☐ Hepatitis	_____
☐ Pneumonia	_____	☐ Bronchitis	_____
☐ Constipation	_____	☐ Diarrhea	_____

Menstrual History (if applicable)

Menopausal ☐ Yes ☐ No Cycle? ☐ Regular ☐ Irregular

Approximate cycle length_____ Flow_____

Independent care for feminine hygiene? ☐ Yes ☐ No

Needs medication for cramps? ☐ Yes Medication name_____ ☐ No

Comments_____

Mobility (check all that apply)

- ☐ Walks without assistance
- ☐ Limps or walks unsteadily
- ☐ Walks with assistance of a walker, cane, etc
- ☐ Unable to walk
- ☐ Uses wheelchair as main form of transport
- ☐ Uses wheelchair for long distances
- ☐ Climbs stairs without assistance
- ☐ Climbs stairs with help
- ☐ Walks up hills without difficulty
- ☐ Walks on uneven surfaces
- ☐ Rides tricycle or bicycle
- ☐ Runs without difficulty

List any adaptive mobility equipment used_____

_____

Diet

What diet texture does the applicant eat?_____

Specify any food or drink restrictions_____

_____

Does the individual use any adaptive eating equipment? If so, what?_____

_____

Any eating problems? (example: poor appetite, compulsive eating, difficulty swallowing, picky eater etc.) _____

_____

_____

Favorite Foods_____

_____

_____

Least Favorite Foods_____

_____

_____

Please explain any serious MEDICAL problems or any special conditions that are not already listed or need detailed explanations:

HEALTH CARE PROVIDERS

CURRENT PRIMARY PROVIDER (family doctor)

Name_____ Phone_____

Address_____

Date of last exam_____

SPECIALISTS

1. Name_____ Specialty_____

   Address_____

   Phone_____ Dates of Treatment_____

2. Name_____ Specialty_____

   Address_____

   Phone_____ Dates of Treatment_____

3. Name_____ Specialty_____

   Address_____

   Phone_____ Dates of Treatment_____

4. Name_____ Specialty_____

   Address_____

   Phone_____ Dates of Treatment_____

PSYCHOLOGICAL / SOCIAL

Check any boxes that describe the applicant's general demeanor.

☐ Calm	☐ Cooperative	☐ Hyperactive
☐ Aggressive	☐ Alert	☐ Industrious
☐ Happy	☐ Disinterested	☐ Irresponsible
☐ Lazy	☐ Reclusive	☐ Cheerful
☐ Moody	☐ Stubborn	☐ Honest
☐ Runs away	☐ Cries easily	☐ Easily corrected
☐ Destructive	☐ Antagonistic	☐ Difficult to manage
☐ Social/Outgoing	☐ Helpful	

How is time occupied when alone? _____

_____

How is behavior in public?_____

_____

How is behavior when with the opposite sex (awareness of sexuality & relationships) ___

_____

Are there any sexual behaviors that would be considered aggressive or inappropriate towards self or others? _____

_____

_____

What sorts of things cause anxiety or disturbance? _____

_____

_____

Explain in detail what kinds of behavior the applicant displays when disturbed? _____

_____

_____

_____

What can be done to help alleviate anxiety or disturbances?_____

_____

_____

_____

_____

Likes/Hobbies

_____

_____

_____

Dislikes

_____

_____

_____

What does the applicant like to do in his/her free time?_____

_____

_____

_____

_____

Please CHECK any behaviors that occurred at least once in the past 3 months and CIRCLE any behaviors that occur once per week or more.

☐ Hits self	☐ Has temper tantrum	☐ Self-stimulates
☐ Hits others	☐ Teases others	☐ Tears clothing
☐ Bites self	☐ Bosses/manipulates others	☐ Kisses inappropriately
☐ Bites others	☐ Disrupts others	☐ Hugs inappropriately
☐ Fakes seizures	☐ Bites fingernails	☐ Spits
☐ Kicks	☐ Grinds teeth	☐ Claims to be ill frequently
☐ Ruminates	☐ Eats inedibles	☐ Chews/sucks inedibles
☐ Pinches	☐ Smears excrement	☐ Undresses at wrong times
☐ Curses	☐ Threatens violence	☐ Hoards objects
☐ Screams	☐ Damages personal property	☐ Talks excessively
☐ Runs away	☐ Damages others' property	☐ Threatens suicide
☐ Lies	☐ Resists following requests	☐ Masturbates in public
☐ Cheats	☐ Takes other's property	☐ Is sexually aggressive

Please describe any other behaviors we should be aware of. _____

_____

_____

_____

_____

_____

_____

_____

Personal Care and Grooming

Check ONE statement that applies:	Independent	Verbal Prompt	Physical Prompts	Total assistance needed
Keeps hands and face clean				
Bathes/showers				
Washes body				
Washes hair				
Dries body				
Dries hair				
Brushes teeth (including applying toothpaste)				
Dresses				
Undresses				
Chooses appropriate clothes for weather/situation				
Knows when clothes need washing				
Operates washer and dryer				
Shaves without assistance – Blade or Electric? (circle one)				
Cares for menstrual needs				
Uses the toilet				
Eats neatly				
Uses fork/spoon				
Uses knife				
Drinks from a cup/glass				

Learning Skills

Check ONE statement that applies:	Independent	Verbal Prompt	Physical Prompts	Total assistance needed
Can tell time on a clock or watch				
Can follow a schedule or routine				
Can count from _____ to _____ (please fill in)				
Can make a vending purchase given money				
Can hold small amounts of money safely				
Can count money for a purchase				
Can count change after a purchase				
Can identify shapes				
Can identify colors				
Can identify sizes				

Communication

Applicant is: ☐ Verbal ☐ Non-verbal ☐ Vocal ☐ Non-vocal

Check ONE statement that applies:	Independent	Verbal Prompt	Physical Prompts	Total assistance needed
Follows simple one-step instructions				
Responds to “stop” “look” “no”				
Responds to own name				
Understands simple sentences				
Understands more complex sentences				
Participates in simple conversation				
Participates in more advanced conversation				
Follows multi-step instructions				
Can identify own written name				
Can read simple words				
Can read more advanced words				
Can write own name				
Can write simple words				
Can write more advanced words				

Independent Living Skills

Check ONE statement that applies:	Independent	Verbal Prompt	Physical Prompts	Total assistance needed
Sets a table for dining				
Removes own dishes from table				
Serves own food from a bowl/plate				
Pours own drinks				
Passes food/drink to others				
Prepares simple drinks				
Prepare simple food items/snacks				
Takes medication from others with pudding				
Takes medication from others with water				
Administers own medication				
Knows time to take medication				
Knows dosage				
Knows name of medication				
Knows side effects of medication				

Dental/Medical History

Client's Name:_____ Date of Birth:_____

Status of Client's current Dental Health: Good_____ Fair_____ Poor _____

Date of Last Dental Visit: _____

Dentist's Name: _____

Dentist's Address: _____

_____

Dentist's Phone: _____

List all medications and dosages client is presently receiving: _____

_____

Please indicate if the client has experienced any of the following:

- ☐ Heart Attack/Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery/Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Artificial Valves
- ☐ Congenital Heart Defects
- ☐ Rheumatic Fever
- ☐ Asthma/Difficulty Breathing
- ☐ High or Low Blood Pressure
- ☐ Anemia/Blood Transfusions
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Artificial Joints or Limbs
- ☐ Arthritis/Rheumatism
- ☐ Cancer/Chemotherapy
- ☐ Problems with Local Anesthetics
- ☐ Others not listed _____

_____

- ☐ Kidney Problems
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Ulcer/Colitis
- ☐ Sinus Problems
- ☐ HIV & AIDS
- ☐ Allergies/Skin Rashes
- ☐ Tuberculosis (TB)
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells
- ☐ Radiation Therapy
- ☐ Problem w/ previous care
- ☐ Allergies_____

_____

Any additional information that would be useful to a dentist treating this client for the first time?_____

_____

_____

_____

Date: _____ Signature: _____