Traditional Care Services; LLC.

Sponsor Residential

Reg, 630

Admission Application Packet

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|  | | |  | |
| Name: Last | First | Middle | Social Security Number: | |
|  | | | | |
| Current Address: | | | | |
|  | |  | |  |
| Current Phone Number: | | Cell Phone Number: | | Work Phone Number: |
|  | | Male or Female | |  |
| Date of Birth: | | Sex: | | Race: |
| Married Single Divorced Widow | | | | |
| Marital Status: Circle one | |  | | |
|  | |
| Medicaid Number: | | Medicare Number: | | |
|  | |  | | |
| Legal Status: | | Name of Legal Guardian: | | |
|  | |  | | |
|  | |  | | |
|  | |  | | |
| Emergency Phone numbers & Contacts | | Legal Guardian Address and Phone Number: | | |
|  | |  | | |
| Proposed Admission Date: | | Admission Date: | | |
|  | | | | |
| Admission Completed by: Date: | | | | |

Traditional Care Services; LLC Confidential Page 1 Pre- admission Comprehensive Assessment

Reg. 650 Traditional Care Service; LLC.

Pre-admission Comprehensive Assessment

**I. Social/ Developmental**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | |  | |  | |
| Individual’s Name: Last First Middle | | | | | Date of Birth: | | Social Security #: | |
| Family Structure | | | | | | | | |
| Name of father: | | | Address: | | | | | Phone Number: |
|  | | |  | | | | |  |
| Name of Mother: | | | Address: | | | | | Phone Number: |
|  | | |  | | | | |  |
| Marital Status of Parents | | |  | | | | | |
| Siblings and Dates of Birth | | | | | | | | |
| Name | | Date of Birth | | Name | | | | Date of Birth |
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| Note: Attach Additional Sheet for Larger Family | | | | | | | | |
| **Others Involved/Extended Family or Friends:** | | | | | | | | |
| Name | Relation | | | Occupation | | Address | | |
|  |  | | |  | |  | | |
| Phone | Notes | | | | | | | |
|  |  | | | | | | | |
| Name | Relation | | | Occupation | | Address | | |
|  |  | | |  | |  | | |
| Phone | Notes | | | | | | | |
|  |  | | | | | | | |
| Name | Relation | | | Occupation | | Address | | |
|  |  | | |  | |  | | |
| Phone | Notes | | | | | | | |
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| Ability to Access Services | | | Yes | | | No | | | |
| Comments | | | | | | | | | |
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| Onset/Duration of Problems | | | |  | | | | | |
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| NARRATIVE ON FAMILY RELATIONSHIP: (Please describe family relationships, family support network, family interests, physical proximity, degrees of contact, etc.) | | | | | | | | | |
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| DOCUMENTATION OF SERVICE REQUESTS AND NEED FOR SERVICES | | | | | | | | | |
| Services requested |  | | | | | | | | |
| By Whom? |  | | | | | | | | |
| Date |  | | | | Rationale | | |  | |
| **INDIVIDUAL’S PREVIOUS SERVICE HISTORY IN STATE FACILITIES, COMMUNITY or MENTAL HEALTH PROGRAMS/PLACEMENTS:** | | | | | | | | | |
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| **CURRENT RESIDENTIAL SITUATION (SELECT ONE ONLY):** | | | | | | | | | |
| Independent Supportive Living Supervised apartment | | | | | | | | | |
| Sponsored placement (foster care) Parents Other Relatives (sister, brother) | | | | | | | | | |
| Domiciliary care (home for adults) Group Home Other (specify) | | | | | | | | | |
| **Pertinent details:** | | | | | | | | | |
| **How long has individual lived in this situation?** | | | | | | | | | |
|  | | | | | | | | | |
| **FINANCIAL AID** | | | | | | | | | |
| **TYPE** | | **YES** | | | | | **NO** | | **AMOUNT** |
| SSI | |  | | | | |  | |  |
| SSDI | |  | | | | |  | |  |
| Medicaid | |  | | | | |  | |  |
| Food stamps | |  | | | | |  | |  |
| Public assistance | |  | | | | |  | |  |
| Other (specify) | |  | | | | |  | |  |
| **Average of Monthly Income: $** | | | | | | | | | |
| **Non-entitlement financial resources:** | | | | | | | | | |
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| **SOCIALIZATION/RECREATION:** | | | | | | | | | | | |
| Member of recreation group Club Church Community Other | | | | | | | | | | | |
| Specify: | | | | | | | | | | | |
| **LEGAL ISSUES** | | | | | | | | | | | |
| Any special legal considerations or actions that have to be completed? | | | | | | | | | | | |
| Court Appearances Specify: | | | | | | | | | | | |
| Lawyer Appointments Specify: | | | | | | | | | | | |
| Representative Payee Guardianship Will (including burial) Probation | | | | | | | | | | | |
| Adjudicated Incompetent | | | | | | | | | | | |
| Explain in detail: | | | | | | | | | | | |
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| **SUPPORTIVE SERVICES REQUIRES BY THIS INDIVIDUAL** | | | | | | | | | | | |
| HISTORY OF: Occupational Therapy Physical Therapy Mental Health Counseling | | | | | | | | | | | |
| Evaluations or assessments available: Yes No | | | | | | | | | | | |
| Current Status: | | | | | | | | | | | |
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| **BEHAVIORAL FUNCTIONING** | | | | | | | | | | | |
| **STRENGTH/INTERESTS** | | | | | | **NEEDS/LIMITATIONS** | | | | | |
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| **Self Help** | | | | | | **Ambulation** | | | | | |
| Independent | | | | | | No Impairment | | | | | |
| Needs some help (specify) | | | | | | Unsteady gait/excessively slow | | | | | |
| Needs total Assistance | | | | | | Ambulation aides/Independent (ie. Crutches, canes, etc) | | | | | |
| **Self Help** | | | | | | **Ambulation** | | | | | |
| Other | | | | | | Needs intermittent assistance | | | | | |
|  | | | | | | Ambulation Aides/requires assistance | | | | | |
|  | | | | | | Wheelchair/independent | | | | | |
|  | | | | | | Wheelchair/requires assistance | | | | | |
| **SPEECH/LANGUAGE CHARACTERISTICS** | | | | | | **RECEPTIVE LANGUAGE** | | | | | |
| Speaks clearly in sentences | | | | | | Understands all/most verbal communication | | | | | |
| Speaks unclear sentences | | | | | | Limited use of manual signs/pictures | | | | | |
| Uses key words (vocab. Under 10 words) | | | | | | Needs major gestural/physical prompts | | | | | |
| Uses Other than words to communicate | | | | | | Needs minor gestural/physical prompts | | | | | |
| Other | | | | | | Other | | | | | |
| **SOUNDS/GESTURES** | | | | | | **MOTOR-FINE** | | | | | |
| Fluent sign or picture symbol communication | | | | | | No impairment with work activities | | | | | |
| No meaningful communication system | | | | | | Limited use of hands (specify) | | | | | |
|  | | | | | | No use of hands | | | | | |
| **BEHAVIOR** | | | | | | **SUPERVISION** | | | | | |
| Can be left alone | | | | | | Does not need supervision | | | | | |
| Often inappropriate | | | | | | Needs limit supervision | | | | | |
| Most often inappropriate | | | | | | Needs constant supervision | | | | | |
|  | | | | | | Other (specify) | | | | | |
| **SIGHT** | | | | | | **HEARING** | | | | | |
| No impairment (includes vision that is correctable) | | | | | | No impairment (include hearing deficit that is correctable | | | | | |
| Visually impaired (not correctable) | | | | | | Hearing impaired (not correctable) | | | | | |
| Profoundly/legally blind | | | | | | Profoundly/legally deaf | | | | | |
| **EDUCATIONAL/VOCATIONAL HISTORY** | | | | | | | | | | | |
| Attended regular education classes | | | | | | Completion date: | | | | | |
| Attended Special Ed classes | | | | | | Completion date: | | | | | |
| Type of Special Ed class: LD ED EMR TMRSPH Homebound | | | | | | | | | | | |
| Name of last school: | | | | | | | | | | | |
| **ACADEMIC SKILLS** | | | | | | | | | | | |
| **Arithmetic Skills** | | | **Word Recognition** | | | | | **Time Awareness** | | | |
| None | | | None | | | | | Unaware of tome | | | |
| Simple Counting | | | Discriminates between common symbols | | | | | Can utilize hour hand for appointments | | | |
| Simple addition/subtraction (numbers over 10) | | | Recognizes some words | | | | | Understands hours and minutes | | | |
| Intermediate skills (multiplications/division) | | | Simple reading (second grade level: reads parts of newspaper) | | | | | Tells time without daily life | | | |
| Advance math skills (above 2nd grade) | | | Advanced reading skills | | | | |  | | | |
| **EMPHASIS (ES) IN LAST TRAINING ENVIRONMENT** | | | | | | | | | | | |
| Academics | | | Self-help skills | | | | | Speech/language | | | |
| Trades/vocational | | | Mobility | | | | | Domestic Skills | | | |
| Leisure/community Skills | | | Other (specify) | | | | | | | | |
| Technical school (specify) | | | | | | | | | | | |
| Work experience/job trials | | | | | | | | | | | |
| Other | | | | | | None | | | | | |
| Comments(special skills, interests, talent): | | | | | | | | | | | |
| **DEPARTMENT OF REHABILITATIVE SERVICES (History)** | | | | | | | | | | | |
| YES NO Received DRS Services | | | | | | Open Case | | | | | |
| If no, explain lack of referral: | | | | | | | | | | | |
| Closed Case/Date/Reason: | | | | | | | | | | | |
| Vocational Evaluation | | | | | | Date Completed: | | | | | |
| Denied/Date/Reason: | | | | | |  | | | | | |
| Work Adjustment /Short term Sheltered Employment: Date Ended: | | | | | | | | | | | |
| Cumulative Months: | | | | | | Name of last facility: | | | | | |
| **EMPLOYMENT HISTORY** | | | | | | | | | | | |
| Never employed | | | | | |  | | | | | |
| Currently employed(job title/place of employment): | | | | | | | | | | | |
| Not currently employed/ previous employment/job title: | | | | | | | | | | | |
| Date of Hire: | | | | | | Avg. hours worked: | | | | | |
| Avg. hourly wage: $ | | | | | | Length of employment: years months | | | | | |
| Date of job release: | | | | | |  | | | | | |
| Reason for job release: | | | | | | | | | | | |
| List other full or part time jobs/ places of employment/length of employment: | | | | | | | | | | | |
| Day Support Program/ contact information: | | | | | | | | | | | |
| Vocational Program/contact information: | | | | | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | |
| Serious illnesses or chronic conditions of individuals parents and siblings (if known): | | | | | | | | | | | |
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| Recent physical complaints/medical problem of individual: | | | | | | | | | | | |
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| Recent treatment: | | | | | | | | | | | |
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| Past serious illness: | | | | | | | | | | | |
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| Infectious diseases including STD’s: | | | | | | | | | | | |
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| Serious injuries: | | | | | | | | | | | |
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| **MEDICAL HISTORY CONTINUED** | | | | | | | | | | | |
| Sexually active: YES NO | | | | | | | | | | | |
| Hospitalizations: | | | | | | | | | | | |
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| NAME OF PHYSICIANS: | | |  | | | | | | | | |
| 1. Name of Doctor | | |  | | | | | | | | |
| Address: | | |  | | | | | | | | |
|  | | |  | | | | | | | | |
| Phone Numbers: | | |  | | | | | | | | |
| 2. Name of Doctor | | |  | | | | | | | | |
| Address: | | |  | | | | | | | | |
|  | | |  | | | | | | | | |
| Phone Numbers: | | |  | | | | | | | | |
| 3. Name of Doctor | | |  | | | | | | | | |
| Address: | | |  | | | | | | | | |
|  | | |  | | | | | | | | |
| Phone Numbers: | | |  | | | | | | | | |
| 3. Name of Dentist: | | |  | | | | | | | | |
| Address: | | |  | | | | | | | | |
|  | | |  | | | | | | | | |
| Phone Numbers: | | |  | | | | | | | | |
| **DRUG USE PROFILE** | | | | | | | | | | | |
| History of Prescription Drugs at time of admission and for the previous six months: | | | | | | | | | | | |
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| History of Non- Prescription Drugs at time of admission and for the previous six months: | | | | | | | | | | | |
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| Drug allergies/idiosyncratic/ adverse drug reactions: | | | | | | | | | | | |
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| Ineffective Medication Therapy: | | | | | | | | | | | |
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| No Substance Abuse History: | | | | | | | | | | | |
| Information provided by: | | | | | | | | | | | |
| **SUBSTANCE ABUSE HISTORY** | | | | | | | | | | | |
| Please mark appropriately: | | | | | | | | | | | |
| Has Abused | Substance | | Amount/Frequency | | | Method | | | Age 1st used | | Date last use |
| Yes No | Alcohol | |  | | |  | | |  | |  |
| Yes No | Marijuana | |  | | |  | | |  | |  |
| Yes No | Amphetamines | |  | | |  | | |  | |  |
| Yes No | Barbiturates | |  | | |  | | |  | |  |
| Yes No | Other sedatives | |  | | |  | | |  | |  |
| Yes No | Tranquilizers | |  | | |  | | |  | |  |
| Yes No | Cocaine | |  | | |  | | |  | |  |
| Yes No | Over the counter | |  | | |  | | |  | |  |
| Yes No | Heroin | |  | | |  | | |  | |  |
| Yes No | Other opiates | |  | | |  | | |  | |  |
| Yes No | Hallucinogens | |  | | |  | | |  | |  |
| Yes No | Inhalants | |  | | |  | | |  | |  |
| Yes No | PCP | |  | | |  | | |  | |  |
| Yes No | Other | |  | | |  | | |  | |  |
| **PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS**  Attach all available reports | | | | | | | | | | | |
| If intellectually disabled is listed as a disability, please provide IQ data upon which diagnosis is based. | | | | | | | | | | | |
| A. IQ Score: | | B. IQ Test Name | | | C. Retardation level: | | | | | D. Date of IQ testing: | |
|  | | Stanford-Binet | | | 1. Borderline | | | | |  | |
| WISC-R, WAIS-R,  Wechsler | | | 2.Mild | | | | |
| Other/Specify: | | | 3.Moderate | | | | |
| List Below | | | 4. Severe | | | | |
| 5. Profound | | | | |
| List other Pertinent Evaluations (include type/date/results): | | | | | | | | | | | |
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| **INDIVIDUAL DISABILITY DESIGNATION** | | | | | | | | | | | |
| Based upon review of diagnostic evaluations and using the following categories, indicate the disabilities in order of severity for this individual. If there are NO secondary and/or tertiary disabilities, write “none” in the space provided. | | | | | | | | | | | |
| Primary Disability: | | | | Secondary Disability: | | | Tertiary Disability: | | | | |
| 1. Autism | | | | |  | | | | | | |
| 2. Cerebral Palsy(including spastic dysplasia) | | | | | 11. Muscular Dystrophy | | | | | | |
| 3. Convulsive Disorder | | | | | 12. Specific Learning Disability | | | | | | |
| 4. Cystic Fibrosis | | | | | 13. Speech/language impairment | | | | | | |
| 5. Emotional Disorder (including chronic mental illness) | | | | | 14. Spinal Bifida | | | | | | |
| 6. Head Injury | | | | | 15. Spinal Cord Injury | | | | | | |
| 7. Hearing Impairment | | | | | 16. Vision Impairment | | | | | | |
| 8. Juvenile Arthritis | | | | | 17. Other Neurological Impairment (specify): | | | | | | |
| 9. Intellectually Disabled | | | | | 18. Other Physical Impairment (specify): | | | | | | |
| 10. Multiple Sclerosis | | | | | 19. Other Genetic Disorder (specify): | | | | | | |

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| --- | --- |
|  |  |
| Name of Person completing application/Title | Date |
|  |  |
| Relationship to applicant/Individual | Date |
|  |  |
| Applicant/Individual signature | Date |

Created 4/10/2014

Traditional Care Services; LLC

Pre-admission Comprehensive Assessment