Traditional Care Services; LLC.

Sponsor Residential

Reg, 630

Admission Application Packet

|  |  |
| --- | --- |
|  |  |
| 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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| 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 |
|  |
| 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:** |
|  |
|  |

|  |
| --- |
| **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: |
|  |
|  |
|  |
| **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 [ ] TMR[ ] SPH [ ] 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: |
|  |
|  |
|  |
| Recent treatment: |
|  |
|  |
| Past serious illness: |
|  |
|  |
| Infectious diseases including STD’s: |
|  |
| Serious injuries: |
|  |
|  |
| **MEDICAL HISTORY CONTINUED** |
| Sexually active: [ ] YES [ ] NO |
| Hospitalizations: |
|  |
|  |
|  |
| 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: |
|  |
|  |
|  |
| [ ] 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