ASHLEY COUNTY SKILLED WORKCENTER, Inc.

P.O. Box 900 ⬩ Crossett, AR 71635 ⬩ 870-364-9253 or 364-2535 ⬩ FAX 870-364-9243
info@acswinc.org

We, at Ashley County Skilled Workcenter, Inc. (ACSW), are excited that you have chosen our workcenter for services and look forward to working with you. Any potential consumer must have been diagnosed with one of the required developmental disabilities (Intellectual Disability, Epilepsy, Cerebral Palsy, Autism, Down Syndrome or Spina Bifida) before his/her 22nd birthday. Potential consumers must also provide a psychological evaluation completed within the past five years. We will also need copies of Guardianship Paperwork, if applicable, and the following cards: Social Security, Medicaid, Medicare, Insurance and Picture ID.

In addition to the application for services, this packet contains forms for your physician to fill out during your physical.

If you have any questions, please feel free to contact a Case Manager at the workcenter.

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APPLICATION FOR SERVICES

Date of Application: ______________________________________

Applicant's Name: ______________________________________

Applicant's Address: ______________________________________

____

Applicant's County: ______________________________________

Telephone: ______________________________________

Legal Status: ______________________________________

Applicant's S.S. Number: ______________________________________

Applicant's Medicaid Number: ______________________________________

Applicant's Medicare Number: ______________________________________

Other Insurance (Company Name) ______________________________________

S.S.I Recipient: ______________________________________

Social Security Disability: ______________________________________

Primary Disability: ______________________________________

Secondary Disability (if applicable) ______________________________________

Services Requested:

Applicant's Physician: ______________________________________

Physician's Address: ______________________________________

____

Physician's Phone Number: ______________________________________

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APPLICATION FOR SERVICES (continued)

Name of Parent/Guardian: ______________________________

Relationship to Applicant: ______________________________

Address: ______________________________

____

Telephone (Home/Work) ______________________________

Telephone (Cell) ______________________________

Emergency Contacts: ______________________________

Telephone (Home/Work) ______________________________

Telephone (Cell) ______________________________

Address: ______________________________

____

______________________________ ____________________

Individual Date

______________________________ ____________________

Parent/Guardian (if applicable) Date

*(Please provide copies of Guardianship Paperwork (if applicable), a psychological evaluation completed within the past five years and the following cards:
Social Security, Medicaid, Medicare, Insurance, Picture ID)*

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ANNUAL PHYSICAL EXAMINATION FORM

Patient Name_______________________________ Date of Birth_________________

Please indicate N if no medical problem(s) exist. If a problem is noted, please check Y and describe in the COMMENTS section on page 2 of this form.

Y	N	Allergies	Y	N	Thorax
Y	N	Head	Y	N	Symmetry
Y	N	Neuromuscular	Y	N	Cardio-vascular
Y	N	Ears	Y	N	Respiratory
Y	N	Hearing Problems	Y	N	Asthma
Y	N	Hearing Aid	Y	N	Abdomen
Y	N	Eyes	Y	N	Gastro-intestinal
Y	N	Contact lens/glasses	Y	N	Urinary
Y	N	Vision Problems	Y	N	Kidney Problems
Y	N	Nose	Y	N	Genitalia
Y	N	Throat and mouth	Y	N	Rectal
Y	N	Teeth	Y	N	Extremities
Y	N	Dentures/false teeth	Y	N	Reflexes
Y	N	Gums	Y	N	Joints/bones
Y	N	Tongue	Y	N	Spine
Y	N	Tonsils	Y	N	Skin
Y	N	Pharynx	Y	N	Special diet needs

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Y N Neck

Y N Lymph glands

Y N Thyroid

Y N Seizures

Y N Bleeding problems

Y N Pregnancy

Y N Contagious disease or febrile illness

Y N Down's Syndrome

Y N Fainting spells

Y N Heat illness/ cold injury

Y N Hernia

Y N Emotional problems

Y N Diabetes

Y N Functional impairment requiring special equipment

Y N Hepatitis

Y N OTHER, Please identify:
____

COMMENTS:

Height: _____________ Weight: ____________ Blood Pressure: __________

Please indicate:

Current medication(s) Amount/time Date prescribed

Note any allergies to medication(s):
____

I have examined the person named above and certify the information contained herein.

_______________ ______________________________________

Date of examination ***Physician's signature***

****NPI#*** ____________________________

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PRESCRIPTION FOR SERVICES

Date: ________________

Individual Served ____________________________

I have examined the above named individual and certify that he/she may participate in

Adult Development, Work Activity, Habilitation, Pre-vocational programs as well as

being furnished Transportation. I concur that their mental or physical disability impairs

them for work outside a sheltered environment.

Physician's NPI# _____________________________

____ ____________________

Physician's Signature ***Date***

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PLAN PARTICIPANTS

________________ Date	____ Individual
________________ Date	____ Physician's Signature
________________ Date	____ Plan Coordinator/Case Manager
________________ Date	____ Parent Guardian
________________ Date	____ ACSW Staff
________________ Date	____ ACSW Staff
________________ Date	____ ACSW Staff
________________ Date	____ ACSW Staff
________________ Date	____ ACSW Staff
________________ Date	____ ACSW Staff
________________ Date	____ ACSW Staff