GUIDING PATHS

Let us show you the way

ADMISSION APPLICATION

Date: _____

Applicant's Full Name: _____

Preferred Name: _____

Social Security Number: _____

Address: _____

Phone (Home and Work): _____

County of Residence: _____

Place of Birth: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female

Briefly state reason for seeking admission:

_____

_____

_____

_____

_____

Primary Diagnosis: _____

Other Diagnosis: _____

Cognitive Level:

□ Mild □ Moderate □ Severe □ Profound

Cause of Intellectual or Developmental Disability:

_____
_____
_____
_____
_____

LEGAL STATUS:

Is the applicant a U.S. Citizen? □ Yes □ No

Has the applicant ever been arrested? □ Yes □ No

If yes, please give details:

_____
_____
_____
_____
_____

Does the applicant have a court appointed guardian or legal custodian? □ Yes □ No

If so, please attach a copy of the guardianship papers.

Name of Guardian(s) / Legal Custodian(s): _____

Address _____

Phone _____

Email _____

FAMILY INFORMATION:

Mother's Full Name: _____

Home address: _____

Business Phone: _____

Cell Phone: _____

Occupation / Employer: _____

Email: _____

Date of Birth: _____

Father's Full Name: _____

Home address: _____

Business Phone: _____

Cell Phone: _____

Occupation / Employer: _____

Email: _____

Date of Birth: _____

Current marital Status of Parents: □ Married □ Separated □ Divorced

(If divorced, please give information regarding current spouse, if applicable)

_____
_____
_____
_____
_____

Please list any other significant people in the applicant's life: (family and non-family, friends, grandparents, etc. Please include their name, address, relationship, and phone number)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

OTHER IDENTIFYING INFORMATION:

Social History:

Where does the applicant currently live (e.g. at home, with relatives, group home, institution, apartment, etc.)?

_____

If living at home with siblings, please list their names and ages:

_____
_____
_____
_____
_____

Marital status of applicant's birth parents: □ Married □ Separated □ Divorced

Are both parents in agreement of this application? □ Yes □ No

If not, please explain:

_____
_____
_____
_____
_____

How often does applicant see his / her family members?

_____
_____
_____
_____
_____

List the hobbies, special aptitudes, and interests of this applicant:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please comment on the applicant's ability to get along with others:

_____
_____
_____
_____
_____

Religious Preference: _____

CHALLENGING BEHAVIORAL CONCERNS *(check all that apply and the frequency of the behavior)*

□ *Verbal Aggression* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____

_____

_____

_____

_____

□ *Tantrums* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____

_____

_____

_____

_____

□ *Self-injurious* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____

_____

_____

_____

_____

□ *Wandering / running away* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____

_____

_____

_____

_____

□ *Inappropriate sexual behavior* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____

_____

_____
_____
_____

□ *Physical aggression* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____
_____
_____
_____
_____

□ *Property damage* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____
_____
_____
_____
_____

□ *Non-compliance* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____
_____
_____
_____
_____

□ *Flopping / dropping on ground* □ Daily □ Weekly □ Monthly

Intensity: □ Mild □ Moderate □ Severe

Explain: _____
_____
_____
_____
_____

Please list any additional challenging behaviors not included in the list above:
_____
_____
_____
_____

Planned Program guidelines: (description)

Additional comments regarding behavioral concerns:

Has a Psychiatrist, state hospital, training center, or mental health center ever treated the applicant for mental health reasons? □ Yes □ No

If yes, please list where and explain the circumstances behind the treatment:

EDUCATION AND EMPLOYMENT:

Current day services, school placement, or job:

Name of Program: _____

Address: _____

Phone Number: _____

Co-ordinator / Supervisor: _____

Educational History (include name of school, program, address, and dates attended):

Work experience (include employer's name, address, phone number, and dates attended):

SAFETY:

How will the applicant respond to a fire alarm?

Can the applicant distinguish between a stranger and a friend? □ Yes □ No

Can the applicant distinguish between an emergency and a non-urgent situation?
□ Yes □ No

Will the applicant be able to dial 911 and convey an emergency situation? □ Yes □ No

Has the applicant ever engaged in any dangerous activities? □ Yes □ No

If yes, please explain:

Are there any other considerations not already listed in this application? □ Yes □ No

If yes, please explain:

Please describe the type and frequency of supervision on a daily basis (e.g. complete supervision, can be in room while watching a movie, etc.)?

PHYSICAL CAPABILITIES, DAILY LIVING SKILLS, AND SUPPORT NEEDS:

Height_____ Weight_____

Food Allergies: _____

Drug Allergies: _____

Please check the area that most clearly matches the applicant's current status:

A) Ambulation

□ Ambulatory

□ Motorized wheelchair

□ Manual chair with no assistance

□ Manual chair with assistance

□ Walker or cane

B) Hearing

□ Normal

□ Impaired

□ Deaf

□ Hearing aid

C) Eating Skills

□ Eats independently

□ Requires verbal prompt

□ Requires physical assistance

□ Requires total assistance *

* Describe:

_____
_____
_____
_____
_____

D) Bathing Skills

□ Independent

□ Requires verbal prompts

□ Requires physical assistance

□ Requires total assistance *

* Describe:

_____
_____
_____
_____
_____

E) Dietary Needs

□ Diabetic

□ Requires special diet *

□ High blood pressure

* Describe:

_____
_____
_____
_____
_____

F) Vision

□ Normal □ Impaired □ Blind □ Glasses

G) Language

□ Verbal □ Non-verbal □ Adaptive communication * □ Manual signs

□ Gestures □ None

* Specify type: _____

H) Toileting Skills

□ Independent □ Requires verbal prompts □ Requires physical assistance

□ Incontinent

I) Dressing Skills

□ Independent □ Requires verbal prompts □ Requires physical assistance

□ Requires total assistance

J) Overnight sleeps / supports

□ Sleeps through the night □ Gets up to go to the bathroom □ Sleeps during the day

□ Bedwetting □ No support required * □ Some support required *

□ Extensive support required *

* Explain:

_____
_____
_____
_____
_____

Additional support considerations, explanations, or comments:

_____
_____
_____
_____
_____

LIVING ENVIRONMENT:

Type of home best suited for applicant:

□ One level □ Multi-level □ Same sex □ Co-ed □ Either

Please explain:

_____
_____
_____
_____
_____

What type of peer group would the applicant prefer?

□ Younger □ Older □ Same age □ Male □ Female □ Either

Please explain:

_____
_____

MEDICAL HISTORY:

Current medical diagnosis or medical concerns:

Current diet:

Allergies: Does applicant have any known allergies to drugs/food? □ Yes □ No

Please describe:

SEIZURE HISTORY:

Does the applicant have a history of seizures? □ Yes □ No

If yes, please give age of onset: _____

Are seizures controlled? □ Yes □ No

If no, what type / frequency?

Does applicant take medication? □ Yes □ No

If so, please identify (list medication name, dosage, frequency, reason for taking, and prescribing doctor).

If prescribed medication, is the applicant able to self-administer medications or is assistance needed (please describe):

Please list any past hospitalizations or operations / medical procedures of this applicant including the name of the hospital, admission / discharge date, and reason for admission:

Please check all of the following tests and immunizations the applicant has had and give the last year he / she received them:

☐ Physical Exam Year: _____

☐ Chest X-ray Year: _____

☐ TB Skin test Year: _____

☐ Flu Year: _____

□ Tetanus Shot Year: _____

□ DPT Year: _____

□ Hepatitis B Year: _____

□ Polio Year: _____

Has applicant been screened for Hepatitis B? □ Yes □ No
If not, screening may be required upon acceptance into a Guiding Paths Inc. program.

What is the applicant's response to medical / dental treatment?

_____
_____
_____
_____
_____
_____

PRIMARY PHYSICIAN INFORMATION:

Please list the practitioner's Name, Address, and Telephone Number:

Primary Physician's Name, Address, and Telephone Number:

_____
_____
_____
_____
_____

Dentist Name, Address, and Telephone Number:

_____
_____
_____
_____
_____

Optometrist Name, Address, and Telephone Number:

_____
_____
_____
_____
_____

Audiologist Name, Address, and Telephone Number:

_____
_____
_____
_____
_____

Podiatrist Name, Address, and Telephone Number:

_____
_____
_____
_____
_____

Psychiatrist Name, Address, and Telephone Number:

_____
_____
_____
_____
_____

Other:

_____
_____
_____
_____
_____

FINANCIAL RESOURCES OF APPLICANT:

Income source (please indicate the amount the applicant receives per month for each income source)

Social Security_____

Supplemental Security Income (SSI) _____

Earned Income _____

Other (please list source and amount) _____

Medicaid: □ Yes □ No

If yes, list county and state: _____

Contact Person: _____

Medicare: □ Yes □ No

Details:

_____
_____
_____
_____
_____

CAP MR/DD: □ Yes □ No Type / Level: _____

Hours of CAP per day: _____

Location of service: _____

Other: _____

Private Insurance: □ Yes □ No

If yes, please list:

Name of insurance company: _____

Type of insurance: _____

Subscriber name: _____

Relationship to the applicant: _____

ASSETS:

Does the applicant have any assets? Please check all that apply:

Bank account(s): □ Yes □ No If yes, type: _____

Real Estate: □ Yes □ No

Stocks: □ Yes □ No

Cash: □ Yes □ No

Trust(s): □ Yes □ No

Burial Plot: □ Yes □ No

Life Insurance: □ Yes □ No
Other: □ Yes □ No

Details: _____

ADDITIONAL INFORMATION:

In the space below, please list any additional information which may be helpful for Guiding Paths Inc. to learn more about the applicant:

How did you hear about Guiding Paths Inc?

The following information should be sent to Guiding Paths Inc. and should be current within (1) year from the date of the application: (If not immediately available to you, these items can be submitted at a later date pending contact from Guiding Paths Inc. Please check each item that you have submitted with this application).

- ☐ Psychological
- ☐ Neurological
- ☐ Dental
- ☐ Physical Therapy
- ☐ Speech Evaluation
- ☐ Guardianship Information
- ☐ Medicaid / Medicare
- ☐ Psychiatric
- ☐ Optometrist
- ☐ Occupational Therapy

☐ Audiological

☐ Social History (Past / Current)

☐ Previous Direct Services Support (include residential)

☐ Social Security

Other:

_____

_____

_____

I certify that all pertinent information in the areas of behavioral challenges, sexual misconduct, physical capabilities, psychological issues, and any incidents which may have occurred in these areas have been submitted to a Guiding Paths Inc. and that no information has been withheld.

I hereby apply for admission to a residential program operated by Guiding Paths Inc. I agree to abide by the rules and regulations of the program, and understand that violations of the rules can result in discharge from the program.

Signature of Applicant: _____ Date_____

Signature of Parent or Guardian: _____ Date_____

Signature of Parent or Guardian (Required if Co-Guardianship)

_____ Date_____

Signature of Person Completing Application *(referral source)*

_____ Date_____

Relationship to Applicant: _____

Agency Address:

_____

_____

_____

Phone Number: _____

Email: _____

**Person to notify in regards to receipt, questions and admissions decision:

_____

Please email, or mail this application:
ATTN: Guiding Paths Inc. Admissions
4213 Dapple Grey Drive
Richmond, Virginia 23223
Phone: (804) 447-1542
P. Mobile: 843-641-8571
Website: www.guidingpaths.org
Email: Guidingpathsinc@gmail.com

Guiding Paths, INC. complies with the requirements of Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973.

Internal use to be completed by Guiding Paths

ADMISSIONS

☐ APPROVED	☐ DENIED
Date:	**Date:**
Group Home Name/Address: ________________ ________________ ________________ ________________ ***Tentative*** Entry Date: ________________ Client Contact: ☐**Yes** ☐**No** **Date:** ________________ *If no, why:* ________________ ________________ ________________ ________________ Guardian Contact: ☐**Yes** ☐**No** Date: ________________ *If no, why:* ________________ ________________ ________________ ________________	**Reason:** ________________
Referral Agency Notified: ☐**Yes** ☐**No** *If no, why:* ________________ ________________ ________________ ________________ **Date:** **Decision Notification Sent:** ☐**Yes** ☐**No** ☐ **Email** ☐ **Mail** ☐ **Fax**	**Referral Agency Notified:** ☐**Yes** ☐**No** *If no, why:* ________________ ________________ ________________ ________________ **Date:** **Decision Notification Sent:** ☐**Yes** ☐**No** ☐ **Email** ☐ **Mail** ☐ **Fax**
Director/Supervisor Notified of Decision: ☐**Yes** ☐**No** **Date:** ________________	**Director/Supervisor Notified of Decision:** ☐**Yes** ☐**No** **Date:** ________________