SYNAPSE HOUSE
ADMISSIONS FORM – 2.01.A

CONSUMER PROFILE

Program: Clubhouse	Community Support Services	Employment		
Referral Date:		Referred by:		
WC or DRS Case #			Last 4 SSN:	
Last Name:		First Name:		
Address:				
City:	State:		Zip:	
County:	Chicago Ward or Neighborhood:			
Is mailing address same as physical address?				
Member's Phone #:		Cell or Home		
Phone #2:	Name:		Relation:	
Phone #3:	Name:		Relation:	
Member's Email Address:				
Contact Email #1:		Name:		
Relation to Member:				
Contact Email #2:		Name:		
Relation to Member:				
Date of Birth:	Age:			
Gender:	Preferred Pronouns:			
Marital Status: Single	Married	Divorced	Widowed	Separated
Race: African American	American Indian	Asian	Asian Indian	
Filipino	Hispanic	Native Hawaiian	White	Mixed
Are you a veteran?				
List any assistive technology or devices that you use (memory device, walker, cane, glasses)				
Special Diet or Swallow Precautions?				
Do you personally have an email address to use?				
Do you have access to internet?				
Do you have a tablet or computer to use?				
Do you need any training in how to use technology?				
Are you experiencing any isolation as a result of COVID-19?				
Do you have any needs due to COVID-19?				
Last Date of a Positive COVID test?				
Do you have any restrictions for wearing a mask or attending in person?				

LEGAL INFORMATION

Legal Representative's Name:
Relationship:
Type of Legal Representative (Circle One): Medical & Decision Making (AMD), Medical POA, Decision Making POA, Any other relative, Authorized Representative, Court Appointed Financial Guardian, Court Appointed Personal Guardian, Family Member, Living Will
Documentation Provided:
Mailing Address:
City: State: Zip:
Phone #:
Do you have advanced medical directives?
Would you like information on advanced medical directives?
Are you registered to vote?
Would you like information on registering to vote?

FINANCIAL INFORMATION

Employment Income Amount (Annually):
SSI (Supplemental Security Income) Amount:
SSDI (Social Security Disability Insurance) Amount:
Military Benefits:
What kind of military benefits?
Pension Amount:
Do you have any dependents?
List anyone who is working with you on financial issues:
SNAP (the Supplemental Nutrition Assistance Program) or Food Stamps?
Section 8 or Housing Subsidies through Housing and Urban Development (Federally administered rent vouchers for people on or below poverty level income)?
HBWD (Health Benefits for Workers w/ Disabilities, Medicaid monthly premiums)?
Other Sources of Income:
List Financial Issues:
Would you like assistance with obtaining or a review of eligible benefits?

MEDICAL INFORMATION

Date of Injury:
Age at Injury:
Type of Brain Injury:

Traumatic Injuries:

	Motor vehicle		Bicycle		Gunshot Wound
	Pedestrian hit		Blast Injury		Fall
	Struck by object		Violence		Other:

Nontraumatic Injuries:

	COVID-19		Infection, meningitis, encephalitis
	Stroke or aneurysm		Drug or alcohol overdose or abuse
	Epilepsy		Progressive disease
	Hypoxia - Lack of oxygen, cardiac arrest, drowning, carbon monoxide, respiratory		

Loss of Consciousness?
Is your injury related to work?
Is your injury related to military action?
Description of Injury:
Who is providing this information?

MEDICAL AND HEALTH ISSUES

Medical & health issues not related to your brain injury:
(Circle) Diabetes, high blood pressure, VP shunt, stomach issues, arthritis, swallowing problems, orthopedic injuries, cardiac issues, clotting, kidney disease, respiratory conditions, muscular-skeletal problems, cancer, autoimmune disease.
Allergy Information:
Seizure History:
Seizure Information (Triggers, description of, implanted device, care afterwards):
Medical Provider:
Do you have any other health or medical needs or information to provide?
Do you have a primary care doctor?
Do you have annual check-ups?
Do you have a dentist?
Have you had a dental exam in the last 12 months?
Do you have any visual deficits or use glasses?
Do you have any hearing deficits or use aids?

HOSPITALIZATIONS & REHABILTIATION SERVICES

Current Service Provider #1:
Type of Services Receiving:
Current Service Provider #2:
Type of Services Receiving:
Prior Service Provider #1:
Type of Services Received:
Prior Service Provider #2:
Type of Services Received:

HEALTH INSURANCE

Insurance Company:
Worker's Compensation Insurance Information:
Medicare (Federally administered health insurance for elderly and disabled)?
Medicaid (Medical Insurance for Poverty level income recipients)?
Medicaid Brain Injury Waiver?

EMOTIONAL & BEHAVIORAL HEALTH

Current Service Provider #1:
Type of Services Receiving:
Prior Service Provider #1:
Type of Services Received:
Reason for Services:
Do you need any counseling or assistance at this time?
Any risk of wandering?
Any risk of physically aggressive behavior?
Any concerns or needs for family wellness?

SUBSTANCE ABUSE

Do you have a history of drinking or using recreational drugs?
Were you using alcohol or drugs at the time of your injury?
Do you or anyone close to you, currently feel that you have a substance abuse problem?
Describe:
Do you need assistance in locating a treatment program?

RESIDENTIAL INFORMATION

Where do you currently reside? House/apartment			Residential Program
Assisted living	Nursing home	Shelter	Homeless
Who do you currently live with?			
Residential Description:			
Describe any housing needs:			
Describe your family support system:			
Describe any family support system needs:			

SOCIAL, RECREATIONAL & COMMUNITY INFORMATION

Describe any social, recreational or community involvement:
Are there any needs related to these areas?

EMPLOYMENT

Current Employer:
Past Employer & Work Experience:
Do you have an open case with DRS?
Describe any interest in returning to work:

TRANSPORTATION

	Drive self		Walk
	Public transportation (bus, train)		Rides from others
	Paratransit #		Bicycle
	Reduced Fare Card #		

VOLUNTEER INFORMATION

List volunteer organization:
Description of volunteer activity:
Describe any interests, strengths or concerns about volunteering:
Describe any concerns related to volunteering:

EDUCATION

Are you currently attending school?			
Name of School:			
Type of School:			
Current Grade:			
Highest Education Level:	Grade School	High School or GED	Technical Training
Some College	Associate Degree	Bachelor's	Master's Degree
Doctorate Degree			
Completed Degree(s) In:			
Pre-Injury Education:			
Post-injury Education:			
Comments:			

CRIMINAL HISTORY

Arrest or Conviction:
Outcome:
Describe current involvement with judicial system:

SERVICE STATUS

Case #
Worker's Comp Case Manager:
Contact Info:
Home Service Program (HSP) Waiver Case Manager:
Contact Info:
DRS Vocational Case Manager:
Contact Info:
DRS Office:
Open Case?

What are the reasons you are seeking services?

	Improve skills at home		Improve skills to maintain or return to school
	Improve skills in community		Improve social network & support
	Improve work skills to maintain or return to work		Improve quality of life and life satisfaction
	Improve work skills to volunteer		

Community Integration Questionnaire

Yes	No	
		Has your life changed regarding friendships?
		Has your life changed regarding romantic relationships?
		Has your life changed with regard to family roles?
		Has your living situation changed?
		Are you satisfied with your social network?
		Are you satisfied with your leisure or recreational activities?

FOR OFFICE USE ONLY

BI First?	Entered by:
Donor Pro Entry?	Entered by:
Salsa Engage?	Completed by:
Google Shared Contacts?	Entered by: