# **SYNAPSE HOUSE**

# **ADMISSIONS FORM – 6.01.A Updated 3.23.24**

**CONSUMER PROFILE**

Program: Clubhouse Community Support Services Employment KNZ Gym Only

Referral Date: Referred by:

WC/DRS/MCO Case # 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?

**NOTE – NOT ALL SECTIONS WILL APPLY TO YOU. PLEASE COMPLETE THOSE SECTIONS THAT APPLY. WE DO NEED THE INFORMATION REGARDING FINANCIAL INCOME COMPLETED IN ORDER TO APPLY FOR NECESSARY GRANT FUNDING.**

**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 HISTORY – Check any that apply.**

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies / Asthma |  | Infections – Drug Resistant (MRSA) |  |
| Arthritis / Osteoarthritis |  | Liver Disease |  |
| Artificial Limbs |  | Lung Disease |  |
| Autoimmune disease |  | Orthopedic Issues |  |
| Back, Spine / Neck  |  | Oxygen Needs |  |
| Blood clots |  | Pacemaker |  |
| Cancer: List location |  | Progressive Diseases |  |
| Cardiac / Heart  |  | Currently Pregnant? |  |
| Congestive Heart Failure (CHF) |  | Splints or Other Devices |  |
| COPD |  | Smoker |  |
| COVID Infection Prior |  | Stomach Issues |  |
| Diabetes |  | Stroke |  |
| Dysphagia (swallowing problem) |  | Prior Ventilator or Tracheostomy |  |
| Feeding Tube |  | Vagus Nerve Stimulator |  |
| Hard of Hearing |  | Visual Deficits |  |
| High Blood Pressure |  | VP Shunt |  |
| Kidney Disease |  | Wounds |  |
| OTHER: |  | OTHER: |  |

**EXERCISE HISTORY**

|  |  |
| --- | --- |
| What type of exercise do you do? |  |
| How many minutes can you do of cardio exercises? |  |

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:

Type of Employment: Transitional Supported Independent

Group Employment One-Day Job Other Customized

**TRANSPORTATION**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Drive self |  | Walk |
|  | Public transportation (bus, train) |  | Rides from others |
|  | Paratransit # |  | Bicycle |
|  | Reduced Fare Card # |  | Uber or Lyft (not part of Paratransit) |
|  | Local Disability |  |  |
|  | Specialized Medical Transport |  | Clubhouse Transportation |

**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 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? |

CPQ Data

Funding Source

|  |  |  |  |
| --- | --- | --- | --- |
|  | Auto Insurance |  | V.A. |
|  | Foundation |  | Worker’s Comp |
|  | PHIP – Private Health Insurance |  | Waiver |
|  | Private Pay |  |  |

Referral Source

|  |  |  |  |
| --- | --- | --- | --- |
|  | Brain Injury Association |  | Physician / Health Care Provider |
|  | Community Mental Health |  | Rehab Facilities (SRAL) |
|  | External Case Manager / Claims Adjuster |  | Self Referral |
|  | Member / Family |  | Social Media Link |
|  | Other Clubhouse Member |  | Support Groups |
|  | Other Service Agency |  | Voc / DRS / HSP Agency |

Co-Morbidities – check if yes

|  |  |  |  |
| --- | --- | --- | --- |
|  | Nicotine Dependent |  | Intellectual Disability |
|  | Alcohol Dependent |  | Mental Health |
|  | Marijuana Dependent |  | Substance Abuse |
|  | Opioid Dependent |  | Other Diagnosis |

Degree of Nicotine Use (Cigarettes / Vaping)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Abstinent / Former Use |  | Severe Tobacco Use |
|  | Moderate Tobacco Use |  | None |

**IMPORTANT**

Synapse House relies on grant funding to be able to provide the services needed. For this, we need information on the financial status of those we serve.

 If your income falls at or below the level listed for the size of your family or as an individual, please check the boxes below.

**What is your household size?**

**FPL Guidelines**

|  |  |
| --- | --- |
| Household Size | Income Level |
| 1 | $22,590 |
| 2 | $30,660 |
| 3 | $38,730 |
| 4 | $46,800 |
| 5 | $54,870 |
| 6 | $62,940 |
| 7 | $71,010 |
| 8 | $79,080 |
| 9 | $87,150 |
| 10 | $95,220 |
| Additional | $8,070 |

Based upon your household size, is your income **less**?

Check box if yes ⬜

**Please complete the questions on the back of this form. This is critical information. Thank you.**

**Median Income Level 50%**

|  |  |
| --- | --- |
| Household Size | Income Level |
| 1 | $39,250 |
| 2 | $44,850 |
| 3 | $50,450 |
| 4 | $56,050 |
| 5 | $60,550 |
| 6 | $65,050 |
| 7 | $69,550 |
| 8 | $74,000 |

Based upon your household size, is your income **less**?

Check box if yes ⬜

**Median Income Level 80%**

|  |  |
| --- | --- |
| Household Size | Income Level |
| 1 | $62,800 |
| 2 | $71,800 |
| 3 | $80,750 |
| 4 | $89,700 |
| 5 | $96,900 |
| 6 | $104,100 |
| 7 | $111,250 |
| 8 | $118,450 |

Based upon your household size, is your income **less**?

Check box if yes ⬜

**Do you receive Medicaid? ⬜**

**Are you a participant in any of the Medicaid Waiver Programs? ⬜**

FOR OFFICE USE ONLY

BI First? Entered by:

Network for Good Entry? Entered by:

Outlook Contacts? Entered by: