**Our Place Day Services**

**Date of Application:**_____

**Name of Applicant:**_____ Date of Birth_____

Address_____

City_____Zip_____

Home:_____ Cell:_____Work: _____

Email address: _____

**Guardian or POA (if applicable)**_____

Address_____

City_____Zip_____

Home:_____ Cell:_____Work: _____

Email address: _____

**Care Manager or IRIS Consultant:**

Name:_____Phone:_____

**Residential Provider or Apartment Support Provider (if applicable):**

Name:_____Phone:_____

**EMERGENCY CONTACT #1**

Name_____

Relation to applicant:_____

Cell:_____ Work:_____ Home: _____

**EMERGENCY CONTACT #2**

Name_____

Relation to applicant:_____

Cell:_____ Work:_____ Home: _____

**Physicians:**

Primary Physician:_____Phone:_____

Dentist:_____Phone:_____

Physician's Name: _____ Specialty_____

Phone:_____

Diagnosis:_____
_____
_____
_____

Health Concerns: _____
_____
_____
_____
_____

**Please complete the attached medication form and please attach a copy of insurance cards to keep on file if emergency treatment is needed.**

Allergies: (What happens and how to respond)_____
_____
_____
_____

Special Diet:_____
_____

Eating Difficulties and help needed:_____
_____
_____

Are there any sounds, lights, scents that bother you?

Physical/emotional/behavioral challenges and support needed:

Class interests:

Gifts and talents:

Work interests:

Do you have an interest in owning your own business?

The thing I am most proud of about myself:

I wish I could… (Finish the sentence):

Anything else you would like to let us know:

Requested schedule?_____
_____

**Transportation Arrangements:**

Do you request transportation services from Our Place Day Services?

Yes_____
No_____

If no, what is your transportation plan?

_____Drive Self

_____Washington County Shared Ride Taxi

_____Family or Friends

_____ Residential/Other Provider of Service

_____ _____
(Signature of applicant) (Signature of Guardian if applicable)

**********

*Office use only*

Date completed application received:_____

Start date:_____

Initial Schedule:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

*Form updated on 2/16/18*

**Our Place Day Services, LLC**
**Medication Information**

**Member's Name: _____ Date: _____**

**Are you currently taking any medication, vitamins or herbal supplements?**

No_____

Yes_____ (If yes, please list current medication below or attach a medication list.)

| Name | Dosage | Time | Reason |
|---|---|---|---|
| | | | |
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| | | | |

**Do you have any allergies to medication? _____No _____Yes (Please list med name & reaction).**

_____

_____

**Will you be taking any medication while at Our Place Day Services?**

_____No

_____Yes

**Please indicate what if any medication assistance is needed:**

_____ Independent (The person carries medication and remembers the correct time and dosage.)

_____Verbal cues needed (The person carries medication but needs someone to remind him/her when to take it and consistently takes medication when prompted to do so.)

_____Physical assistance needed (The person needs someone to administer the medication and document that it has been given.)

**Do you have diabetes?**

**_____If no stop here and sign form _____If yes please indicate below the support needed.)**

_____Can independently monitor blood sugars and respond appropriately if a snack or insulin is needed.
_____Needs help to monitor and log blood sugars. If so please indicate times taken.
_____Needs help to determine what to do if blood sugars are high or low.
_____Needs help administering insulin.

Who is the primary contact for any medication or diabetic concerns?

_____

_____ _____

Signature of person completing form and date Signature of member or guardian if applicable and date

*(Form updated on 2/16/18 NG)*