CARE AFFILIATES BEHAVIORAL HEALTH SERVICES

Admission Form

PERSONAL DATA

Name: _____ Record Number: _____

Preferred Name: _____Date of admission: _____

Address: _____ Phone: _____

Legal county of residence: _____

Age: ____ Date of Birth: _____ Social Security #: _____

Medicaid #: _____ Medicare #: _____

Physical Description

Sex: _____ Race: _____ Citizenship: _____ Language Spoken: _____

Height: _____ Weight: _____ Color of Eyes: _____ Color of Hair: _____

Identifying Marks: _____

Religious Preference: _____

Financial Support: Social Security ____; Medicaid ____; VA ____; Other ___

Case Manager's Name: _____ Phone: _____

Parents: Father's name: _____

Address: _____

Place of Birth: _____ Phone: _____

Place of Employment: _____ Phone: _____

Mother's Maiden name: _____

Address: _____

Place of Birth: _____ Phone: _____

Place of Employment: _____ Phone: _____

Marital status of parents: _____

Name of Siblings Address Phone

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/ _____

REFERRAL DATA

Referral Source: _____

Name Of Agency (If applicable): _____

Address of Agency (If applicable): _____

Phone Number of Agency (If applicable): _____

Name Of Case Worker or Agency Contact: _____

Reason for Referral: _____

_____

_____

Name of Person Completing Application: _____

Name Of Person Who Transported the Child and Agency:

_____

Name or GAL and Contact information (If applicable):

_____

Probation officer (If applicable):

_____

GUARDIANSHIP AND NEXT OF KIN INFORMATION

Type of guardianship: _____

County of Adjudication: _____ Date of Adjudication: _____

Guardian: _____ Phone: _____

Address: _____

Next of Kin: _____ Phone: _____

Address: _____

Emergency Contact: _____ Phone: _____

Address: _____

CURRENT DIAGNOSES, DSM IV (Attach supporting documentation)

NAME NUMBER

AXIS I Diagnosis 1 _____ _____

Diagnosis 2 _____ _____

AXIS II Diagnosis 1 _____ _____

Diagnosis 2 _____ _____

AXIS III Diagnosis 1 _____ _____

Diagnosis 2 _____ _____

Date of Last Psychological Evaluation: _____ Measured IQ: _____

Examiner: _____

Date of Adaptive Behavior Evaluation: _____ Results: _____

Examiner: _____

Level of Adaptive Functioning: ___Mild ___Moderate ___Severe ___Profound

INDEPENDENT LIVING ABILITIES (Check appropriate box)

Ambulation: ___ Walks well ___ With difficulty ___ Uses walker

___ Does not walk ___ Uses a wheel chair

___ Crutches ___ Cannot sit alone

Dressing Skills: ___ Completely dresses self

___ Completely dresses self with verbal prompt

___ Pulls off or puts on clothes with help ___ Must be dressed

Toileting Skills: ___ Never has accidents ___ Occasionally has accidents during day

___ Occasionally has accidents during night

___ Frequently has accidents during day ___ # day

___ Is not toilet trained ___ Bedwetting ___ Frequency

Bathing Skills: ___ Prefers shower ___ Prefers tub ___ Bathes independently

___ Needs supervision to bathe ___ Needs partial assistance bathing

___Needs total assistance bathing

Leisure Skills: ___ Entertains self ___ Needs direction from others

Likes: ___ TV ___ Music ___ Outdoor activities

___ Privacy ___ Groups ___ Sports ___Swimming

___ Movies ___ Games ___ Other _____

SUPERVISION NEEDED

INDOORS: ___ Needs constant supervision ___ Can be left alone for up to _____

OUTDOORS: ___ Needs constant supervision ___ Can be left alone for up to _____

SOCIALIZATION

___ Initiates interaction with people ___ Initiates interaction selectively

___ Interacts with peers, staff, family ___ Interacts with staff, but not peers and family

___ Never, or rarely interacts with staff, peers and family

EXPRESSIVE COMMUNICATION

___ Uses expressive language clearly ___ Initiates expressive language with difficulty

___ Uses expressive communication and gestures

___ Uses augmentative communication ___ Uses selective vocalizations

___ Uses ASL ___ Uses signs

RECEPTIVE COMMUNICATION

___ Comprehends most spoken language ___ Comprehends little spoken language

___ Responds to gestures or auditory cues ___ attends to gestures or auditory cues

___ Does not respond to communication stimuli

Alleghany County Group Homes, Inc.

APPLICATION FOR ADMISSION

forms\Admission Application

SKILLS CHECKLIST (If the applicant can perform these skills, fill in the corresponding

block with a “Y” for yes and a “S” for sometimes. Leave blank for no.)

SELF-HELP SKILLS

___ Uses knife and fork correctly ___ Table manners are acceptable ___ Can serve his/her own food

___ Can pour liquids ___ Can use knife for peeling/slicing ___ Can order own food

___ Combs hair when needed ___ Keeps self-clean ___ Shaves self

___ Shampoos hair ___ Cuts own nails without prompt ___Chooses appropriate clothes

___ Changes underwear without prompt ___ Washes and dries clothing

___ Crosses road safely by self ___ Visits neighbors by self ___ Can care for minor injuries

___ Knows how to obtain help in emergency ___ Washes dishes, sets table

___ Cleans own room, picks up after self ___ Can cook simple things

COMMUNICATION SKILLS

___ Tells others about daily events ___ Can answer telephone ___ Can make own calls

___ Can tell time correctly ___ Can keep appointments ___ Can write own name

___ Can write a letter ___ Reads simple instructions ___ Reads menu, TV guide

___ Reads newspaper ___ Reads aloud to others ___ Can read price tag

SOCIAL SKILLS

___ Can read shopping list ___ Chooses own clothing ___ Can ask directions

___ Is friendly to others ___ Understands and uses stamps ___ Has good manners

___ Does not steal ___ Knocks on doors before entry ___ Shares possessions

___ Works cooperatively in group ___ Washes dishes, sets table ___ Follows directions willingly

___ Can cook simple things ___ Saves money consciously

COMMUNITY SKILLS

___ Can give change for a quarter ___ Can give change for dollar ___ Can use vending machine

___ Can make small purchases ___ Can buy things on shopping list ___ Knows own clothing size

___ Purchases own clothing ___ Asks sales clerk for items ___ Saves money consciously

___ Can ask for directions ___ Uses public transportation unassisted

VOCATIONAL SKILLS

___ Has good manual dexterity ___ Works cooperatively in group ___ Follows directions well

___ Enjoys outdoor activities ___Has hobbies ___ Is on time by self

___ Works with little supervision ___ Works well with few mistakes ___ Corrects own mistakes

___ Realizes mistakes, stops work ___ Work done requires checking ___ Is usually on time

___ Usually on time with reminders ___ Careful with tools and equipment ___ Careful when reminded

___Works well with little supervision, but makes no effort to find a new job

___ Is able to carry out several simple tasks with persistence and without constant supervision

COMMENTS: _____

_____

PHYSICAL HEALTH CARE NEEDS

Allergies: _____

_____

_____

EMERGENCY CONTACT: _____ Phone: _____

Preferred Physician: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Is Applicant currently under care of a doctor for any condition? ___ Yes __No

List illnesses or medical conditions: _____

_____

_____

_____

_____

Seizures: ___ Yes ___ No Type and Frequency _____

List any medications for seizures: _____

Diet or regimen required? ___ Yes ___No (Attach Copy)

MEDICATIONS

Medications brought in at admission:

_____

_____

Name Dosage & Frequency Route Purpose

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SELF-ADMINISTRATION OF MEDICATIONS

___ Can take medications in right doses at right time ___ Can prepare and take medications with reminder

___ Can take medications; needs help with preparation ___ Unable to take medication without assistance

Person responsible for assisting: _____ Relationship: _____

VISION, HEARING AND DENTAL

___ Normal ___ Sees with difficulty ___ Sees with great difficulty ___ Legally blind

___ Totally blind ___ Undetermined

Corrective Lenses? ___ Yes ___ No ___ Glasses ___ Contact lenses

Hearing: ___ Normal ___ Mild hearing loss ___ Moderate Hearing loss

___ Severe hearing loss ___ Profound hearing loss ___ Undetermined

Hearing aid? ___Yes ___ No

Dental Appliances? ___ Yes ___ No

COMMENTS: _____

_____

_____

BEHAVIORAL CONCERNS

Does the applicant display any behaviors which are of concern to others? ___ Yes ___ No

If so, please rate all that apply as follows: I = severe; 2 = moderate; 3 = mild

___ Self-stimulation ___ Assaultive behavior ___ Stealing

___ Loses temper easily ___ Verbal threats ___ Self-injurious behavior

___ Property damage ___ Excessive crying/screaming ___ Non-compliance

___ Lying ___ Purposeful running away ___ Aimless wandering away

___ Inappropriate sexual behavior ___ Eating of in-edibles

Please explain all above rated behaviors: _____

_____

_____

_____

Any other information that you would like us to know: _____

_____

_____

_____

_____

Signature of Applicant: _____ Date: _____

Signature of Guardian or

Legally Responsible Person: _____ Date: _____

Care Affiliates Residential Home Employee: _____ Date:_____

Uploaded
Date:_____