ATHELAS INSTITUTE, INC.
Application for Admissions (For Day Programs Use ONLY)

APPLICANT'S INFORMATION

Name: _____
Last First Middle

Date of Birth: _____/_____/_____ Medicaid/ Medical Assistance #: _____

Current Address: _____
Street City State Zip

Previous Address: _____
(If current is less than 10years) Street City State Zip

Telephone #: (_____)-_____-_____ Social Security #: _____- _____- _____

Ethnic Identification **(completion is not required)**:

___ African American ___ Caucasian ___ Hispanic ___ Native American ___ Asian

___ Other: _____ Sex: ____ Male _____ Female U.S. Citizen? ____Yes ___ No

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Language(s) spoken or understood: ___ English ____ other, specify: _____

Language(s) spoken in applicant's home: ___English ___Other, specify: _____

EMERGENCY CONTACTS (use additional paper if necessary)

1. Name: _____ Relationship to Applicant: _____

Address: _____ Best way to contact? _____

Tel #: _____ Cell/Work #: _____ Email: _____

2. Name: _____ Relationship to Applicant: _____

Address: _____ Best way to contact? _____

Tel #: _____ Cell/Work #: _____ Email: _____

GUARDIAN/ CAREGIVER INFORMATION:

Name: _____ Relationship to Applicant: _____

Address: _____

Telephone #: _____ Cell/Work #: _____

Email Address: _____

What is the best time and way to reach you? _____

LIVING SITUATION:

Parents: _____ Guardian or Relatives: _____

Foster Home: _____ Other: _____

Address: _____ Phone Number: _____

Legal Guardian: ☐ Yes ☐ No If yes, name: _____ Date Attained: _____

Number of Occupants living in the home: _____

Type of Guardianship (check which applies): ☐ Full ☐ Property ☐ Limited ☐ Medical ☐ Person

FAMILY INFORMATION:

Parent Information:

	Father	Mother
Name		
Address		
Home Phone		
Cell Phone		
Business Phone		
Email Address		
Date of Birth		
Deceased (yes/no)		
Date of Death		

Siblings/Other Members Living in the Household (use additional paper if necessary):

Name			
Address			
Phone			
Relationship to Applicant			
Date of Birth			

FINANCIAL INFORMATION (Complete only if seeking residential services):

SSI Claim #: _____ SSI Amount: _____

SSA Claim #: _____ SSA Amount: _____

Name of representative payee/relationship to Applicant: _____

Other Sources of Applicant's Income: _____

Account Types: ☐ Checking ☐ Savings Bank Name: _____

Property in Applicant's name (list location & value): _____

Trust Fund: ☐ Yes ☐ No Type: _____

If yes, give name & address of trustee: _____

MEDICAL INFORMATION:

A. Diagnoses:

1. Primary Diagnosis: _____
2. Additional Diagnosis: _____
3. Additional Diagnosis: _____

B. Medications (use additional paper if necessary):

Medication	Dosage	Frequency	Purpose/ Reason

C. Insurance Information:

Applicant's Medicaid/ Medical Assistance #: _____

Dates Covered under Medicaid/Medical Assistance: _____

Applicant's Medicare #: _____ Type: _____

Other Medical Insurance (list company name and policy #) _____

_____

D. Physician and Dentist Information:

Applicant's Primary Physician: _____

Address: _____

Phone #: _____ Familiar Hospital: _____

Applicant's Dentist: _____

Address: _____ Phone #: _____

Does Applicant wear dentures? ☐ Yes ☐ No Dental Problems? _____

E. Vision and Hearing:

Does the Applicant have a vision impairment? ☐ Yes ☐ No

Is the Applicant legally blind? ☐ Yes ☐ No

Does the Applicant wear? ☐ Glasses ☐ Reading Glasses ☐ Contact Lenses

Does the Applicant have a hearing impairment? ☐ Yes ☐ No

Does the Applicant wear a hearing aid? ☐ Yes ☐ No

Is the Applicant deaf? ☐ Yes ☐ No

F. Seizures:

Does the Applicant have seizures? ☐ Yes ☐ No Frequency: _____

Type: _____ Are seizures controlled by medication? ☐ Yes ☐ No

G. Speech and Language:

Does the Applicant have a speech or language impairment? ☐ Yes ☐ No

Is the Applicant verbal? ☐ Yes ☐ No

Has the Applicant had a speech/language assessment? ☐ Yes ☐ No

Assessment completed by: _____ Date of assessment: _____

Means of Communication:

☐ Speech ☐ Sign Language ☐ Gestures ☐ Communication Board

H. Mobility:

☐ Walks Independently ☐ Uses Cane ☐ Uses Crutches ☐ Uses Walker ☐ Uses Wheelchair

Type of wheelchair: _____ Can the user transfer independently? ☐ Yes ☐ No

Can the Applicant cross streets? ☐ Independently ☐ With Assistance ☐ No

Can the Applicant use mass transit? ☐ Independently ☐ With Assistance ☐ No

Is the Applicant certified to use Paratransit/ MTA Mobility? ☐ Yes ☐ No

Does the Applicant have an MTA buss pass? ☐ Yes ☐ No

I. Other:

Does the Applicant have any other medical conditions not listed above? _____

_____

Has the Applicant had any significant surgeries or hospitalizations? _____

_____

Does the Applicant have a special diet, use adaptive dishes/utensils, or need feeding assistance?

_____

Does the Applicant have any allergies (environmental, medication, food, etc)? _____

_____

Does the Applicant: ☐ Use the bathroom independently ☐ Wear diapers
☐ Need transfer assistance

MENTAL HEALTH/ PSYCHOLOGICAL:

Applicant's Current Psychiatrist: _____

Address: _____ Phone #: _____

Applicant's Current Psychologist: _____

Address: _____ Phone #: _____

Applicant's Current Therapist: _____

Address: _____ Phone #: _____

Does the Applicant have behavioral problems? ☐ Yes ☐ No

Does the Applicant have a current behavior intervention plan in school? ☐ Yes ☐ No

If yes, briefly explain below (use additional paper if necessary): _____

_____

_____

EDUCATION:

Schools or Adult Programs Attended (use additional paper if necessary):

Program/School	Address	Dates Attended

Vocational Programs or Trainings Attended (use additional paper if necessary):

Program	Address	Dates Attended

SKILLS:

1. Is the Applicant independent in personal self-care skills? ☐ Yes ☐ No
2. Can the Applicant self-medicate: ☐ Yes ☐ No
3. Is the Applicant capable of remaining home unsupervised? ☐ Yes ☐ No

   If yes, for how long: _____
4. Can the Applicant read? ☐ Yes ☐ No If yes, what level: _____
5. Can the Applicant write? ☐ Yes ☐ No If yes, what level: _____
6. What time doe the Applicant usually go to bed? _____ Get up in the morning? _____
7. Does the Applicant usually sleep through the night? ☐ Yes ☐ No
8. What does the Applicant like to do in his/her free time? _____

   _____
9. Please provide a brief description of the Applicant's daily routine: _____

   _____

   _____

   _____

   _____
10. Has the Applicant or currently receiving any types of services or financial assistance (i.e. Rolling Access Funds, Respite services, In-Home Support Services, Foster Care, etc)? If yes, please list below:

_____

_____

EMPLOYMENT:

Is the Applicant currently employed? ☐ Yes ☐ No

If yes, what is the employment address: _____

Phone #: _____ Supervisor's Name: _____

Job Title: _____ Start Date: _____ Wage: _____

Duties: _____

_____

Previous Employment (Use additional paper if necessary):

_____

Company Name Address Phone #

_____

Job Title Supervisor's Name Dates Employed

_____

Company Name Address Phone #

_____

Job Title Supervisor's Name Dates Employed

If the applicant is not currently employed, what are their job interests? _____

_____

ADDITIONAL TEAM MEMBERS:

Does the Applicant have a Service Coordinator? ☐ Yes ☐ No

If yes, please state name and phone number: _____

Does the Applicant have a DORS Counselor? ☐ Yes ☐ No

If yes, please state name and phone number: _____

Does the Applicant have Social Worker? ☐ Yes ☐ No

If yes, please state name and phone number: _____

SIGNATURES:

_____ _____
Signature of Applicant if over 18 Date

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of Person Completing this form Date

FOR OFFICE USE ONLY

Date application was received: _____

Critical needs list: ☐ Yes ☐ No

Level of services approved:

☐ Day Habilitation

☐ Residential

☐ In- Home Support Services

☐ Supported Employment

☐ Medical Day Habilitation

Comments/Notes: _____

_____

_____