Bethel Day Program

Application for Services

Date of Application: _____

Applicant's General Information:

Applicant's Name: _____ (First, MI, Last Name)

Current Address: _____

Phone Number: _____ Date of Birth: _____

Does Applicant have a Legal Guardian? ____Yes _____ No

Legal Guardian: _____

Address: _____

Phone Number: _____

Type of Guardianship (check whichever is applicable): ___ Full ___ Property ___ Limited ___ Medical

Provider Information:

Name: _____ Relationship to Applicant: _____

Address: _____

Phone #: _____ Email: _____

Service Coordinator: _____ Phone #: _____

Email: _____

Emergency Contact #1:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #_____

Emergency Contact #2:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #_____

Medical Information:

Applicant's Primary Health Care Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

Date of Last Physical Exam including TB Test (Copy must accompany Application): _____

Date of last Dental Screening: _____

Date of last Vision Screening: _____

Diagnoses:

_____

_____

Diet Orders:

___Regular

____Pureed

___Soft

___Small bites (size): _____

___Mechanical soft

___ NPO

___Thickened Liquids

___Other (specify):_____

Tube Feeding ___No ___Yes Type and amount: _____

Time(s):_____

Water and amount: _____

Other special instructions: _____

Risk of Choking: ___No ___Yes (if yes, what precautions should be put in place to ensure safety?)

_____

Adaptive Equipment:

_____

_____

_____
_____

Physical Limitations:

___No

___Yes (please indicate): _____

Review of ALL Current Medications:

***Please attach current medication list**

***All Current Medications for the individual must be reviewed by the physician annually**

Means of communication:

___ Speech

___ Sign Language

___ Gestures

___ Communication Board

___ Other (Describe): _____

Allergies (bee stings, drugs, dust, mold, food, etc.): _____

Does the Applicant have any implanted devices? If yes, please list:

_____

Does the Applicant have any other medical problems not listed above? If Yes, Please list:

_____
_____
_____

Does the Applicant:

____ Toilet independently

____ Wear adult protective undergarments

____Require staff assistance for personal care

____ Other (Please explain):

_____

Does the Applicant have a history of behavioral problems? ___ Yes ___ No (if yes, describe below)

Maladaptive Behavior Frequency Severity Intervention

_____
_____
_____
_____

Does the Applicant have a behavior plan? ___ Yes ___ No (***if yes, please attach copy**)

Skills Checklist:

A. Is the Applicant independent in personal self-care skill? ___ Yes ___ No (If No, please explain)

_____
_____
_____
_____

B. Can the Applicant self-medicate? ___ Yes ___ No

C. Can the Applicant cross streets? ___ Independently ___ With assistance ___ No

F. Can the Applicant read? ___ No ___ Yes, at _____ level

G. Can the Applicant write? ___ No ___ Yes, at _____ level

H. What does the Applicant like to do with his/her free time?

_____
_____
_____
_____
_____

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent/Guardian (if applicable) Date

_____ _____

Signature of Person Completing the Form Date