ICF-DD PROGRAM

APPLICATION FOR ADMISSION

Please provide all critical health and safety information to provide an accurate picture of the individual being considered for admission. Withholding critical information may result in denial of services of discharge from services for the individual.

Please enclose a copy of:

- ❒ Most current psychological evaluation
- ❒ Most current history and physical exam
- ❒ Birth certificate
- ❒ Photo ID
- ❒ Immunization records (to include TB skin test results current within past five (5) years)
- ❒ Proof of disability prior to age 22
- ❒ Copy of guardianship papers - if applicable
- ❒ Copy of Medicaid card, Social Security card, Medicare card(s)

Please return completed packet to:

Elizabeth Richardson Center
2006 Kim Ave.
Springdale, AR 72764
ATTN: Admission Committee

Please direct any questions to:

Admissions Committee

Phone: 479-872-4657

Fax: 479-872-4667

Date of Application: _____

SECTION 1: General Information

Applicant's Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number (home):_____ (Other):_____

Email:_____

Social Security Number:_____

Medicaid Number:_____

Medicare Number:_____

Insurance Info:_____

_____

Race: ❒ Caucasian ❒ African-American ❒ Hispanic ❒ Asian ❒ Other_____

Sex: ❒ Male ❒ Female

Disability: (Primary):_____

(Secondary): _____

Financial: SSI (amount): $_____ Social Security (amount): $_____

Other: (amount) $_____

Person completing form:_____ Relationship to applicant:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone number(s):_____

Email Address:_____

Has guardianship been established by a court of law? ❒ Yes ❒ No (Please check only one box.)

Who serves as legal guardian?_____

What areas are covered by guardianship? _____

Guardian's Address:_____

City:_____ State:_____ Zip:_____

Phone number(s):_____

Mother's Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone number(s):_____

Email Address:_____

Father's Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone number(s):_____

Email Address:_____

Emergency Contact: _____ Relationship_____

Phone number(s):_____

Information on others living in applicant's home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section 2. Early Childhood Information

Where was the applicant born: _____

Did mother suffer from any unusual illnesses or injuries during pregnancy? If so, what?_____

_____

Length of pregnancy?_____

Any complications during delivery? If so, what?_____

_____

Weight of applicant at birth? _____ Length of applicant at birth?_____

Any abnormalities noted at birth? If so, what?_____

When was disability evident, if not at birth? _____

List any problems during early childhood: _____

_____

_____

Section 3. Medical History

Does applicant have any medical needs? If yes, please describe: _____

_____

_____

_____

List all medications, vitamins, or supplements the applicant is currently taking. Please include name, dosage, time(s) given, purpose:

Medication/Supplement	Dosage	Time(s) given	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does applicant have any drug or food allergies? ❒ No ❒ Yes If YES – to what?

_____

_____

_____

_____

Does applicant have any psychological or learning disorders? ❒No ❒Yes If YES – please explain.

_____

_____

_____

Please list all medical or psychological professionals the applicant has seen in the last five (5) years?

Name Address Phone Number

_____

_____

_____

_____

_____

_____

Family Health History:

Family Member	Age	Status of Health	Age at Death	Cause of death or poor health
Father	____	_____	_____	_____
Mother	____	_____	_____	_____
Brothers	____	_____	_____	_____
	____	_____	_____	_____
	____	_____	_____	_____
	____	_____	_____	_____
Sisters	____	_____	_____	_____
	____	_____	_____	_____
	____	_____	_____	_____
	____	_____	_____	_____
Children	____	_____	_____	_____
	____	_____	_____	_____
	____	_____	_____	_____

Check diseases known to have occurred in the family:

❒Diabetes ❒Tuberculosis ❒Allergies ❒Heart disease ❒Ulcers ❒Arthritis
❒Asthma ❒Sick headaches ❒Convulsions ❒Cancer ❒Colon Polyps
❒High blood pressure ❒Kidney Disease

Check diseases the applicant has had:

❒Measles ❒Chicken Pox ❒Polio ❒Whooping cough ❒Mumps
❒Pneumonia ❒Asthma ❒Rheumatic fever ❒Scarlet fever

Does applicant use tobacco products? ❒No ❒Yes If YES – what amount:_____
How long as the applicant used tobacco? _____

Does applicant drink alcohol? ❒No ❒Yes If YES – amount?_____ How long?_____

SECTION 4. Strengths, Needs and Interests

Description of abilities (Please check all that apply.)

Walk: ❒ Independently ❒ With assistance ❒ Unable ❒ Uses a wheelchair ❒ Uses a walker ❒ Uses crutches

Toileting: ❒ Independent ❒ With assistance ❒ Incontinent of bladder ❒ Incontinent of bowel

Talking: ❒ Single words ❒ Simple sentences ❒ Gestures ❒ Sign language ❒ Non-verbal

Feeding: ❒ Independent ❒ With assistance ❒ Requires adaptive equipment

Bathing: ❒ Independent ❒ With assistance

Dressing: ❒ Independent ❒ With assistance

Vision: ❒ No correction necessary ❒ Wears glasses

Hearing: ❒ No correction necessary ❒ Wears hearing aids

List adaptive equipment needs:_____

_____

Is applicant used to being away from parents? _____

Does applicant sleep alone? ❒ Yes ❒ No If not, with whom?_____

Does applicant have any sleeping problems such as nightmares, bedwetting, sleepwalking, insomnia, etc. _____

_____

Does applicant enjoy socializing with peers? _____

Applicant's favorite foods?_____

_____

Any significant dislikes? _____

_____

Any special dietary needs? _____

_____

Does applicant drink…?

Milk ? ❒ Yes ❒ No Fruit juice? ❒ Yes ❒ No Soft drinks? ❒ Yes ❒ No

Is applicant right or left handed? ❒ Right handed ❒ Left handed

Is any other language (other than English) spoken at home? If so, what?_____

Does applicant understand and respond to simple commands? ❒ Yes ❒ No

Does applicant read? ❒ Yes ❒ No Does applicant write? ❒ Yes ❒ No

Can applicant use a telephone? ❒ Yes ❒ No

Describe any socially inappropriate behaviors:_____

_____

_____

_____

_____

What disciplinary measures are taken? _____

_____

_____

_____

_____

Does applicant take medication (currently or in the past) that is used to control behavior? If so, what and when? Is the medication effective?

_____

_____

_____

_____

Has applicant ever been hospitalized or institutionalized due to behavior? If so, where? When?

_____

_____

_____

What problems does the applicant have in his/her present situation?

_____

_____

_____

What is the reason for locating other living placement? _____

_____

_____

_____

How does the applicant get along with other roommates? _____

_____

_____

_____

What would the ideal roommate be like for the applicant? _____

_____

_____

_____

Is the applicant in a school/training program or working? If so, where?_____

_____

What assistance do you feel the applicant needs and why? _____

_____

_____

How do family members get along? _____

_____

_____

How has the family adjusted to the applicant? _____

_____

_____

What feelings/behaviors does the applicant exhibit toward other family members? _____

_____

_____

_____

What goals would you like to see the applicant achieve? _____

_____

_____

_____

How can the family help?_____

_____

List services that have been utilized:

Name Address Dates utilized?

_____

_____

_____

_____

_____

Is the applicant currently pending placement on Medicaid Waiver program? ❒No ❒Yes If yes, when was the application completed? _____

Please feel free to use the space below for any additional information you wish for us to know.

_____

_____

_____

_____

_____

_____