This agency does not discriminate because of race, color, Creed, age, sex or national origin or religion. Information Will be held in the strictest confidence. Please complete in Full, Print legibly. You may use the back of the pages Using ink if you need additional space.

DO NOT WRITE IN THIS SPACE
1. **Date application sent**
2. **Date application rec'd**
3. **Date of admission**

APPLICATION FOR ADMISSION

I. Identifying Information:

Name:_____
(First) (Middle) (Last)

Current Address:_____
(Street) (City) (State) (Zip) (County)

Permanent Address:_____
(Street) (City) (State) (Zip) (County)

Telephone Number:_____ Social Security #:_____

Birthdate:_____ Place of Birth:_____

Sex:_____ Color of Hair:_____ Color of Eyes;_____

Weight:_____ Height:_____

Identifying Marks:_____

Person(s) to Notify in Case of Emergency

_____
(Name) (Relationship)

_____
(Name) (Relationship)

Address:_____
(Street) (City) (State) (Zip) (County)

Telephone:_____
(Home) (Work)

Medicare # _____ Medicaid # _____

Citizenship Status:_____

Marital Status:_____ Maiden Name:_____

Tribal Registration Number:_____

Reason for Referral:_____

Services Requested:_____

Referral Source:_____
(Name) (Agency) (Address) (Phone)

Referral Source:_____
(Name) (Agency) (Address) (Phone)

II. Guardianship Information:

1. Has the applicant ever been declared incompetent by a court of law? ____Yes ____No

2. If yes, please complete the following:
   Date of court appearance:_____

   Please describe conditions of guardianship (limited, full, person, estate, etc)
   Type of guardianship: _____Full _____Limited _____Person _____Estate _____Other

   Describe specifically, the terms of the guardianship established:_____

   _____
   (Attach a copy of guardianship papers to the application)

3. County/Tribal Court where guardian action occurred:_____
   Individual(s) appointed as legal guardian:

   Name:_____

   Address:_____
   (Street) (City) (State) (Zip)

   Telephone Numbers:_____
   (Home) (Work)

   Name:_____

   Address:_____
   (Street) (City) (State) (Zip)

III. Financial Information

1. Social Security _____ Yes _____No $_____
2. Supplemental Security Income (SSI) _____Yes _____No $_____
3. Veterans Benefits _____ Yes _____No $_____
4. Railroad Benefits _____ Yes _____No $_____

5. Other Benefits _____ Yes _____No $_____

6. If applicant does not receive any of these benefits, has he/she applied for any?
_____ Yes _____ No If yes, which one(s)?_____

7. Other Income:
   a. Wages $_____
   b. Interest $_____
      stocks/bonds $_____
      joint savings accounts $_____
   c. Lease income $_____
   d. Payments from U.S. government
      For land held in trust $_____
   e. Property Owned (home, machinery, vehicles).
      _____
      _____
   f. Other (specify)_____

8. Does applicant have money in a checking account? _____ Yes _____ No $_____

_____
Bank Name Address Account Number

Is interest added to the account balance? _____ Yes _____ No $_____

9. Does applicant have money in a savings account? _____ Yes _____ No $_____

_____
Bank Name Address Account Number

Is interest paid by check? _____ Yes _____ No $_____

10. Does applicant have Certificates of Deposit with a Bank or Savings and Loan Association?

_____ Yes _____ No $_____

_____
Bank Name Address Account Number

Is interest paid by check? _____ Yes _____ No $_____

11. IM Account? _____ Yes _____ No $_____
(Indian Land Lease)

12. Does the applicant have a Representative Payee appointed by the Social Security Administration?

_____ Yes _____ No

_____
Name of Payee Address Phone Number

13. Life Insurance. List all policies that may make payment to beneficiary.

Name of Company	Address	Policy #	Annual Premium

14. Health Insurance. List all insurance except Medicare or Medicaid which included coverage and may Make payments for physicians services, hospitalization, nursing home care or drugs, and policies that May make cash payments during any spell of illness.

Name of Company	Address	Policy #	Annual Premium

15. Prepaid Burial Arrangements. Does applicant have money in an account or on deposit?

If yes, where?_____ How Much?_____

Is interest paid applicant on this account? _____ Yes _____ No
Are there any specific burial instructions?

_____

_____

IV. Service History

List schools, adjustments training centers, vocational rehabilitation, public and/or private hospitals, Clinic, mental health centers, and other facilities where applicant has received treatment, evaluations or training.

	From	To	Place/Address	Reason for Leaving
Current Placement:				
Prior Placement(s)				

ICAP Service Score _____

V. Residential Information

Does the applicant have housing available? _____ Yes _____ No

If yes, name and address:_____

If no, who will make the arrangements?_____

What types of living arrangements does applicant need?_____

_____

Does applicant require out agency's assistance? _____ Yes _____ No

What have applicant's prior living arrangements been?_____

What day-to-day responsibilities does the applicant have in present living situation (cleaning, cooking, other domestic chores, etc.)? Please describe

_____

_____

VI. EMPLOYMENT HISTORY

(Please include work and volunteer experiences)

1. Has applicant been competitively employed? _____ Yes _____ No?

Employer (include address, Supervisor's name)	Dates	Type of work/duties	Reason for Leaving

2. Were any of the work experiences provided through Division of Rehabilitation Services?

_____Yes _____No

3. Does applicant have any work restrictions? _____ Yes _____ No
If yes, be specific (Examples, lifting, standing, bending, dust, humidity, heat, noise Etc.) _____

4. Does applicant have a valid South Dakota drivers license? _____ Yes _____ NO

Drivers license # _____ Expiration date:_____

5. Has applicant been convicted of a crime? _____ Yes _____ No

Please explain:_____

I authorize investigation of all statements contained in the application. I understand that Misrepresentations or omission of facts is cause for dismissal

The agency is a point of referral and will provide assistance into the service delivery system for eligible individuals. All approved admissions into the agency training program are considered temporary and may be times limited depending on the needs of the individual. Once admitted to the program, continuation of service will be determined by the individual's Planning team. The applicant and if appropriate his/her family are important members of this planning team.

_____ _____

Signature of individual completing form **Date**

Address:_____

Applicant's signature or mark:_____

Parent/Guardian Signature:_____

ENTRY SOCIAL ASSESSMENT

1. Applicant's Name:_____
(First) (Middle) (Last)

Spouse's Name:_____
(First) (Middle) (Last)

Children's Names:_____
(Age)

_____
(Age)

_____
(Age)

2. Mother's Maiden Name:_____
(First) (Middle) (Last)

Address:_____ Telephone #:_____

Birthdate_____ Social Security #:_____
(Month) (Day) (Year)

Place of Birth:_____

Current Marital Status:_____ Education (Last grade completed):_____

Occupation:_____

If deceased, cause of death:_____

3. Father's Name:_____
(First) (Middle) (Last)

Address:_____

Birthdate:_____ Social Security #:_____
(Month) (Day) (Year)

Place of Birth:_____

Current Marital Status:_____ Education (Last grade completed):_____

Occupation:_____

If deceased, cause of death:_____

4. Applicant's marital status/history:_____

5. Please list siblings below:

Name	Date of Birth	Address

6. Developmental History:

At what age did applicant:

Sit up by self _____ Walk _____

Crawl _____ Talk _____

Stand by self _____ Independently toilet _____

7. All of us interact differently with different people, depending on our personalities, frequency of contact, etc. Does applicant have a close relationship to a certain family member(s)?

Please describe:_____

_____

_____

8. Does applicant have a difficult relationship with family member(s)?

_____

_____

_____

9. Please check the items that describe the applicant's behavior, as objectively as possible. This Information is needed to plan for the person's best interests to make sure we have enough Resources to help him/her.

Check all that apply

_____ Friendly, seeks out others for social contact.

_____ Gets along with others, but does not seek them out.

_____ Quiet, not very active, withdrawn

_____ Unusual or repetitive behaviors (such as rocking, finger twirling, etc.) Please describe:

What appears to "cause" this behavior?_____

How often/how long do these outbursts last?_____

_____ Intentionally hurts self. Please describe:_____

_____

What appears to "cause" this behavior?_____

How often/how long does this happen?_____

_____Sometimes physically aggressive toward others. Please describe:_____

_____

What appears to "cause" this behavior?_____

How often?_____

_____Disruptive behavior (such as frequent tantrums, screaming or other emotional outbursts).

Please describe:_____

What appears to "cause" this behavior?_____

How often/how long do these outbursts last?_____

_____Potentially dangerous to others or self. Please describe:_____

_____

What appears to "cause" this behavior?_____

How often/how long?_____

_____Takes others possessions. Please describe:_____

What appears to "cause" this behavior?_____

10. Are there any behavioral changes in applicant due to recent events such as death, birth, marriage, Divorce, accident, or other trauma? Please describe:_____

_____

_____

11. If natural parents are divorced or separated, are there any restrictions or special feelings on home visits or relationships due to this situation? Please describe:_____

_____

_____

12. Please describe applicant's living arrangements for the last five years (for example: living in an institution, foster home, family, relative, independently, _____

_____

13. Please check applicant's most familiar environment: _____ Rural _____ Farm _____ Small Town _____ City _____Unknown

14. Please indicate the language spoken in the family home: _____

15. Does the applicant use an alternative communication system?_____

16. Please describe frequency and circumstances of applicant's contacts with the family in the past (such as letters, visits, phone calls). Can the applicant expect to receive visits from family, relatives, or friends at this agency?_____

_____

_____

17. Should applicant make visits home? _____ Yes _____ No How often?_____

How long should the visits be?_____

Are any special arrangements needed?_____

_____

_____

List relatives or friends with whom applicant can leave the agency for visits:_____

_____

_____

18. Does applicant have a close relationship to some non-family person (for example: friend, advocate, neighbor, boyfriend/girlfriend, etc.)? _____

_____

_____

19. Please describe frequency and circumstances of the applicant's contact with non-family persons in the past year (such as visits, letters, phone calls): _____

_____

_____

20. Does applicant have awareness/concerns about human sexuality? Please describe (for example: Concerns about relationships/dating, need for information/education, is sexually active, is fearful of persons of the opposite sex, etc.):_____

_____

_____

21.

Please check how applicant Generally relates to:	Very Good	Good	Fair	Poor	No Contact
Teachers					
Employers					
Parents					
Siblings					
Co-workers					
Friends					
Relatives					
Persons in Authority					
Strangers					
His/Her disability					

22. What hobbies does the applicant have? Please list, including how often:_____

_____

23. What recreation (leisure activities) does the applicant like to do? Please describe, including how often:_____

_____

24. Please list any groups or organizations applicant participates in (service clubs, church groups, etc:

_____

_____

25. Does the applicant have any food preferences?_____

_____

Food dislikes:_____

Are there any cultural, ethnic or religious constraints regarding food?_____

_____

Other customs?_____

26. Does the applicant have any personal possessions or preferences of special meaning?_____

_____

27. Does applicant use tobacco or alcohol? Please explain:_____

_____

28. Does the applicant have any fears that the agency should be aware of (i.e., thunderstorms, the dark, etc?_____

29. What time does the applicant generally go to bed each night?_____

What time does the applicant generally get out of bed in the morning?_____

Please check any of the following which apply to the applicant: _____ Sleep Walks;

_____ Wanders during night; _____ Has nightmares; _____ Naps during the day

Comments:_____

30. Please check the effect one or more of the following items have in helping the applicant learn:

LEARNING STYLE	MOST EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
Physical assistance/prompts			
Verbal assistance/prompts			
Demonstration			
Verbal instructions			
Written instructions			
Praise			
Constructive criticism			
Rewards			
Peer pressure			
Opinion of friends/family			

31. Please describe any special abilities or strengths the applicant has:_____

_____

32. Please describe any unusual problems or needs the applicant has:_____

_____

33. Please give any additional information about the applicant which you feel may help the agency's Admissions and Placement Committee to make an informed decision:_____

_____

_____

34. Source(s) of information:_____

_____

_____

Signature of individual completing Entry Social Assessment

_____

Relationship to applicant or title:

_____

Date

MEDICAL INFORMATION

Applicant's Name:_____
(First) (Middle) (Last)

1. List applicant's disability(ies):_____

   _____

   _____

2. Age of onset:_____

3. Cause of disability:_____

4. Hospital Preference:_____

5. Allergies (Please describe symptoms also):

   Medications(s):_____

   _____

   Food:_____

   _____

   Other:_____

   _____

6. Does applicant have special dietary needs? _____ Yes _____ No
   (specific food consistency, adaptive equipment, positioning, etc.)

   Please explain:_____

7. Does applicant have seizures? _____ Yes _____ No

   Age of onset:_____ Frequency:_____

   What type of seizure has been diagnosed?_____

   Describe behavior prior/during/after seizure:_____

   _____

   _____

6. Please circle any corrective/adaptive equipment used:

Eye glasses dentures walker contact lenses orthopedic braces

Language board/book hearing aid cane wheelchair crutches handsplints

Feeding machines special eating utensils (list) _____

Other:_____

9. Is applicant receiving physical therapy? _____ Yes _____ No

Services provided: (include schedule):_____

_____

Therapist's name:_____

10. Is applicant receiving occupational therapy? _____ Yes _____ No

Services provided (include schedule):_____

_____

35. Please check if applicant can do the following:

A. Arm and hand use
___ move arms
___ move hands
___ hold objects
___ use both hands together
___ focus on people and objects
___ do simple 5 piece puzzle
___ trace simple figures

B. Feeding
___ swallow pureed foods
___ drink from cup
___ handle firm foods (toast)
___ feed self finger foods
___ suck from straw
___ use cup independently
___ feed self with spoon
___ feed self with fork
___ use table manners
___ chews using rotary motion
___ needs total assistance
___ tube feed

C. Toileting

___ toilets independently
___ indicate when wet
___ void when placed on toilet
___ stay dry all day
___ stay dry all night
___ indicate need to void
___ indicate need to have BM
___ get to bathroom independently
___ undress for toileting
___ transfer to toilet
___ flush toilet
___ rearrange clothing appropriately
___ wash hands
___ dry hands
___ change sanitary napkins (if applicable)

D. Dressing

	Take off	Put On
socks	_____	_____
underwear (briefs, panties)	_____	_____
T-shirt	_____	_____
bra (if approp)	_____	_____
shoes	_____	_____
shirt or blouse with buttons	_____	_____
pants or skirt	_____	_____
jacket	_____	_____

___ button	___ unbutton
___ snap	___ unsnap
___ hook & eye	___ unhook
___ tie	___ untie
___ lace	___ unlace
___ zip	___ unzip

36. Please check if the applicant has problems with the following:
_____ choking ___ swallowing liquids ___ incontinence:___ bladder ___ bowel ___ both

37. Does the applicant wear diapers? ___ Yes ___No If not, is the applicant on a toileting Schedule? ___ Yes ___ No

Describe:_____

PHYSICIANS:

1. General Medical

   Physician:_____ Clinic:_____

   Address:_____
   (Street) (City) (State) (Zip)

   Telephone Number:_____

   Date of last exam:_____

2. Dental

   Physician:_____ Clinic:_____

   Address:_____
   (Street) (City) (State) (Zip)

   Telephone Number:_____

   Date of last exam:_____

3. Psychiatric

   Physician:_____ Clinic:_____

   Address:_____
   (Street) (City) (State) (Zip)

   Telephone Number:_____

   Date of last exam:_____

4. Neurological

   Physician:_____ Clinic:_____

   Address:_____
   (Street) (City) (State) (Zip)

   Telephone Number:_____

   Date of last exam:_____

5. Other (Dermatologist, orthopedist, opthamologist, etc.)

   _____

   _____

   _____

38. Medications the applicant is currently taking:

Name:______________________________ Name:___________________________

Dosage:_____________________________ Dosage:__________________________

Reason Prescribed:____________________ Reason Prescribed:__________________

Prescribing Physician:_________________ Prescribing Physician:________________

Side effects observed:_________________ Side effects observed:________________

____________________________________ __________________________________

Name:_______________________________ Name:____________________________

Dosage:______________________________ Dosage:___________________________

Reason Prescribed:_____________________ Reason Prescribed:__________________

Prescribing Physician:__________________ Prescribing Physician:________________

Side effects observed:_________________ Side effects observed:_________________

____________________________________ __________________________________

Name:_______________________________ Name:_____________________________

Dosage:______________________________ Dosage:____________________________

Reason Prescribed:_____________________ Reason Prescribed:___________________

Prescribing Physician:__________________ Prescribing Physician:________________

Side effects observed:__________________ Side effects observed:_________________

_____________________________________ __________________________________

Name:_______________________________ Name:_____________________________

Dosage:______________________________ Dosage:____________________________

Reason Prescribed:_____________________ Reason Prescribed:___________________

Prescribing Physician:__________________ Prescribing Physician:________________

Side effects observed:_________________ Side effects observed;_________________

____________________________________ __________________________________

Have there been any changes in medications and/or dosages in the past 3 months? Why?

_____

39. Does applicant have any current or chronic medical problems? _____

_____

40. Does applicant have any current emotional problems?_____

41. Personal History

Has applicant had?

	Yes	No	Date		Yes	No	Date
Scarlet Fever	___	___	____	Recurrent Headaches	___	___	
Measles	___	___	____	Surgery (specify)	___	___	
German Measles	___	___	____	_____	___	___	
Rheumatic Fever	___	___	____	Recurrent Colds	___	___	
Mumps	___	___	____	Gallbladder Disease	___	___	
Chicken Pox	___	___	____	Bloody Stools	___	___	
Malaria	___	___	____	Recurrent Diarrhea	___	___	
Tuberculosis	___	___	____	Jaundice	___	___	
Gum/Tooth Problems	___	___	____	Stomach Problems	___	___	
Sinusitis	___	___	____	Recent Weight Gain/Loss	___	___	
Eye Trouble	___	___	____	Joint Disease	___	___	
Ear, Nose, Throat	___	___	____	Back Problems	___	___	
problems (specify)				Skin Disorders	___	___	
Head injury	___	___	____	Tumor, Cancer, Cysts	___	___	
Hay Fever/Allergies	___	___	____	Venereal Diseases	___	___	
Asthma	___	___	____	Sugar in Urine	___	___	
Shortness of Breath	___	___	____	Frequent Urination	___	___	
Chest Pain/Pressure	___	___	____	Pain on Urination	___	___	
Rapid Heartbeat or	___	___	____	Polio	___	___	
Palpitations				Hepatitis	___	___	
High Blood Pressure	___	___	____	Constipation	___	___	
Heart Murmur	___	___	____	FEMALES ONLY			
Dizziness/Fainting	___	___	____	No. of Pregnancies	___	___	
Weakness/Paralysis	___	___	____	Irregular Periods	___	___	
Insomnia	___	___	____	Severe Cramps	___	___	
Frequent Anxiety or	___	___	____	Excessive Flow	___	___	
Depression				Lack of Menses	___	___	
				PMS	___	___	

Comments:_____

_____

_____

42. Family Medical History

Have any of applicant's blood relatives had any of the following? Please check appropriate Boxes and specify relationship

Yes	No		Relationship
___	___	Heart Attack	_____
___	___	Stroke	_____
___	___	High Blood Pressure	_____
___	___	Diabetes	_____
___	___	Asthma	_____
___	___	Hay Fever	_____
___	___	Elevated Cholesterol	_____
___	___	Congenital Heart Disease	_____
___	___	Kidney Disease	_____
___	___	Glaucoma	_____
___	___	Obesity	_____
___	___	Cancer	_____
___	___	Arthritis	_____
___	___	Epilepsy or Convulsions	_____
___	___	Heredity Disorders or Congenital abnormalities (specify)	_____
___	___	Blood Disorder	_____
___	___	Other (specify below)	_____

_____

_____

_____