



Where it All Comes Together
for a Better Future

Admission Application for Day Habilitation Services Table of Contents

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Section I - GENERAL INFORMATION

Full Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Gender: Male Female

Race: _____

Religion: _____

Date of Birth: _____

City of Birth: _____

Hospital: _____

Marital Status: _____

Language Spoken: _____

Language Understood: _____

Height: _____

Weight: _____

Hair Color: _____

Eye Color: _____

Identifying Marks: _____

MassHealth Card #: _____

Social Security #: _____

Other: _____

Legally Competent? Yes No

If No, Name of Legal Guardian: _____

Date of Court Confirmation: _____

Relationship to Applicant: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____ Other: _____

Emergency Contact Name: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____ Other: _____

Alternative Contact Name: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____ Other: _____

Section II - FAMILY HISTORY

Mother: Living Deceased Date of Birth: _____

Full Name: _____

Address: _____

City, State, Zip: _____

Employer: _____

Employer Address: _____

Telephone: Home: _____ Work: _____ Other: _____

Father: Living Deceased Date of Birth: _____

Full Name: _____

Address: _____

City, State, Zip: _____

Employer: _____

Employer Address: _____

Telephone: Home: _____ Work: _____ Other: _____

Siblings:

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Socio-Cultural Information: _____

Family Contact:

How often is family in contact with applicant? What family members? _____

Family Medical History:

Condition	Yes	No	Relation	Comments
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		
GI Disturbances	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>		
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>		
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Chemical Dependency (i.e. tobacco, alcohol, drugs)	<input type="checkbox"/>	<input type="checkbox"/>		

Section III – MEDICAL PROFILE

Condition	Yes	No	Condition	Yes	No
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	GI Disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with Sight	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Infect. Mono.	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Disabilities: _____				<input type="checkbox"/>	<input type="checkbox"/>

Explain any of the above conditions, if necessary: _____

Seizure History: (completed even if seizures are presently under control) _____

Date of First Seizure: _____

Date of Last Seizure: _____

Describe seizures, i.e. body movements, duration: _____

Frequency of seizures, i.e. 3-4 days, 1-2 month: _____

Current seizure medication: _____

Physician managing seizure: _____

Chemical Dependency History:

Does applicant use tobacco products? Yes No

If yes, please specify the type and frequency and supervision needed: _____

Does applicant consume alcoholic beverages? Yes No

If yes, please specify the amount and frequency: _____

Does applicant have any history of illegal drug use? Yes No

If yes, what type? _____

Has applicant received any treatment for chemical dependency? Yes No

Please specify: _____

Other Medications: (include name, dosage, reason for use, length of use) _____

Allergies:

Medication: _____

Food: _____

Other: _____

Former Hospitalizations/Operations: _____

Section IV – ASSESSMENTS

Please attach any documentation, forms or recent reports.

Primary Physician:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Neurologist:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Psychologist:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Psychiatrist:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Ophthalmologist:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Audiologist:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Dental:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Physical Therapy:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Occupational Therapy:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Speech Therapy:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Section V – SELF-HELP & COMMUNITY SKILLS

Please briefly describe the following:

Communication (verbal, sign, gestures, etc.):

Expressive: _____

Receptive: _____

Eating:

Food preparation: _____

Supervision Needed: _____

Special Diet: _____

Personal Hygiene: What assistance needed?

Using toilet: _____

Washing hands: _____

Brushing teeth: _____

Dressing: _____

Mobility:

Does person walk? _____

Can person ride in a van? _____

Does person require any special consideration for transportation? _____

Likes (items, activities): _____

Dislikes (items, activities): _____

Social Interactions with Others (describe in general): _____

Section VI – BEHAVIORAL ISSUES

Please forward a copy of recent psychological evaluation.

Is the individual at risk to self or others? Identify any known fears, behaviors, disciplinary problems. Describe as accurately as possible; if additional space is required, use the back of this sheet or additional sheets. _____

Behavior programs: (past/present; known behavioral antecedents; identify reinforcers) _____

General attitudes and motivation: _____

Section VII – EDUCATIONAL/WORK PLACEMENTS

Educational History:

Please list all schools attended and grades completed.

School	Address	Years Attended

Vocational/Day Program History/Competitive Employment:

Please list all programs beginning with the most recent.

Name	Address	Years Attended	Description of Services

Residential History:

Residence	Address	Years Resided

Section VIII – SUMMARY REPORT

Please indicate reason(s) for referral, projected length of stay, and anticipated goals and objectives. _____

Attached is a photocopy of:

- MassHealth Card
- Social Security Card
- Comprehensive Evaluation (i.e. IEP, ISP, assessments from another day program)
- Physical Examination within 12 months of application
- If Nursing Home Resident, PASSAR and letter recommending specialized services
- Immunization Record
- Guardianship Documentation
- Psychological Evaluation

Signature of Member: _____

Signature of Parent/Guardian: _____

Signature of Other/Title: _____

Date of Completion: _____

Please note the first 30 days of admission is a period of assessment to determine permanent placement in the program. Individual must have at least an 85% attendance rate during that 30-day period, unless otherwise agreed upon.