DISABILITY RESOURCES, INCORPORATED
APPLICATION FOR ADMISSION (Confidential)

Residential / Vocational Program
Date of Application _____
Date of Placement Desired _____

_____ _____
Applicant's Full Name Date of Birth

_____ _____ _____ _____
Street Address City State Zip Code

(___) _____ _____ _____ _____ _____
Telephone Social Security # Height Weight Sex

Marital Status (check one): _____ Never Married _____Separated

_____ Divorced _____ Widowed _____ Married

I. FAMILY HISTORY

Father's Name _____

Home Address _____ Zip _____

Occupation & Name of Firm _____

Home Phone _____ Business Phone _____

Mother's Name _____

Home Address _____ Zip _____

Occupation & Name of Firm _____

Home Phone _____ Business Phone _____

Religious Affiliation of Applicant _____

Please indicate the person or agency that referred you to us.

_____

Please list family references in the following categories:

1. Personal: Name _____ Phone _____

Address _____ Zip _____

2. Professional: Name _____ Phone _____

   Address _____ Zip _____

3. Financial: Name _____ Phone _____

   Address _____ Zip _____

II. LEGAL STATUS

_____ Adult or _____Minor
Please enclose copy of legal guardianship papers if applicable
_____ Adult with Guardian or Person and Estate
_____ Adult with Guardian of Person only
_____ Adult with Guardian of Estate only
_____ Adult with Temporary Guardian

III. SCHOOLS OR PROGRAMS ATTENDED

Check all situations in which the applicant has participated and complete the following information on each situation. (Please use additional pages if more space is needed.)

_____ Group/Family Care Home
_____ Independent Living Situation
_____ State Hospital
_____ Public Schools
_____ Competitive Employment
_____ Rehabilitation
_____ Prevocational Training
_____ Sheltered Workshop
_____ Day School
_____ Other, explain _____

1. Name _____ Dates _____

   Address _____

   Type of situation (refer to above list) _____

   Reason for leaving _____

   Person to contact for more information _____

2. Name _____ Dates _____

   Address _____

   Type of situation (refer to above list) _____

   Reason for leaving _____

   Person to contact for more information _____

3. Name _____ Dates _____

Address _____

Type of situation (refer to above list) _____

Reason for leaving _____

Person to contact for more information _____

4. Name _____ Dates _____

Address _____

Type of situation (refer to above list) _____

Reason for leaving _____

Person to contact for more information _____

IV. PSYCHO-EDUCATIONAL EVALUATIONS

1. Please include, with this application, copies of any available educational evaluations that have been given your child or ward.

2. If the applicant has had any of the following, please give name of the professional and dates and include copies of any available reports.

	Yes	No	Date	Professional
Psychiatric Evaluation	___	___	_____	_____
Psychiatric Therapy	___	___	_____	_____
Psychiatric Hospitalization	___	___	_____	_____
Speech & Language Assess.	___	___	_____	_____
Hearing Assessment	___	___	_____	_____
Medical Evaluation	___	___	_____	_____
Visual Examination	___	___	_____	_____

V. PERSONAL APTITUDE AND INTERESTS

Describe the applicant in relation to the following areas:

Diagnosis_____
_____
_____

General Health_____
_____
_____

Special Medical Problems_____
_____
_____
_____
_____

Motor Abilities _____
_____

Peer Relationships _____
_____

Daily Routine/Activities _____
_____

Leisure Activities _____
_____

Specific Aptitudes & Interest (woodcraft, hand crafts, etc.) _____
_____
_____

Special Handicaps & Disabilities _____
_____
_____

Please state what you consider the applicant's strengths to be. _____
_____
_____

Please state what you consider the applicant's weaknesses to be. _____
_____
_____

Please describe activity area and/or situations that the applicant strongly dislikes. _____
_____
_____

Please describe your goals and expectations for the applicant and what you hope that Disability Resources can accomplish. _____
_____
_____

VI. FUNCTIONAL LIMITATION AREAS

A. SELF CARE: Applicant often needs the help of another person or a mechanical device, or takes a long time, to take care of:

Personal hygiene – toileting, washing and bathing, tooth brushing	Yes	No
Grooming – dressing, undressing, hair and nail care, overall.	Yes	No
Feeding – eating/drinking, use of utensils, chewing, swallowing	Yes	No
Needs to be prompted to take care of personal hygiene, grooming or feeding.	Yes	No

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B. RECEPTIVE AND EXPRESSIVE LANGUAGE: Applicant needs daily assistance from another person, or a person with special skill (such as sign language) or mechanical device to communicate (verbally or non-verbally).

Expressive: Has difficulty speaking intelligibly.	Yes	No
Has difficulty sharing information or communicating wants or needs.	Yes	No
Receptive: Has difficulty hearing (without a hearing aid)	Yes	No
Has difficulty understanding an ordinary conversation	Yes	No

C. LEARNING: Applicant needs special assistance to aid learning. The applicant may be unable, or very limited in their ability, even with special intervention, to acquire knowledge or to transfer knowledge or skills to new situations.

The applicant may have difficulties with:

Cognition – recognition of persons, places, events or objects	Yes	No
Retention – short and/or long term memory	Yes	No
Reasoning – ability to grasp concepts, to perceive "cause and effect" relationships, ability to generalize information and skills from one situation to another.	Yes	No
Academic skills – reading and/or writing, numerical concepts (arithmetic, money and value of objects)	Yes	No

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D. MOBILITY: Applicant needs the assistance of another person or a mechanical device, or takes a long time, or requires a barrier-free environment, in moving from place to place in their home or community.

NOTE: This does not refer to the ability to operate motor vehicles or use public transportation.

Applicant needs or uses crutches, walker, or wheelchair for mobility	Yes	No
Applicant walks independently, but takes a long time due to gait and/or coordination difficulties.	Yes	No

Applicant requires assistance in performing activities requiring manual dexterity, fine motor control, or eye-hand coordination, such as using locks, appliances or light switches. Yes No

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THE FOLLOWING MAJOR LIFE ACTIVITIES (SELF-DIRECTION AND CAPACITY FOR INDEPENDENT LIVING) MUST BE CONSIDERED IN RELATION TO AGE APPROPRIATENESS.

E. SELF-DIRECTION: Applicant needs help in making judgements and decisions concerning their personal or social life. They may also need someone to help protect their interests or rights (property rights, civil rights, voting rights).

Emotional Development – Applicant needs help to routinely cope with fears, anxieties or frustrations; emotionally unstable; exhibits low self esteem Yes No

Interpersonal/Family Relations – Applicant needs help in establishing and maintaining relationships with family or peers; lacks social maturity and awareness; is unable to protect self from exploitation Yes No

Initiative – Applicant needs help to make independent decisions regarding daily schedules or time management, unable to manage personal finances or initiate routine medical care. Yes No

Personal Independence – Applicant needs help make major life decisions concerning work, marriage, voting, where to live. Yes No

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F. CAPACITY FOR INDEPENDENT LIVING: The applicant is unable to live independently or to maintain normal societal roles, and may present a danger to him/herself without the assistance or supervision of another person.

Applicant needs help to perform simple household tasks such as bed making, sweeping, and washing dishes. Yes No

Applicant needs help managing multiple step activities such as meal planning and preparation, house cleaning, laundry (care and selection of clothing), home repair and maintenance, household and personal safety. Yes No

Applicant needs help using the telephone, using public transportation, or going shopping. Yes No

Applicant needs help comprehending rules, restrictions, laws or contracts. Yes No

Applicant has physical impairments that prevents him/her from living independently unless support services (such as home care services), special equipment, accessible environments, and/or skills training are provided. Yes No

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G. BEHAVIORAL: Please describe in detail.

Self abusive _____
_____

Passive _____
_____

Aggressive _____
_____

Verbal hostility _____
_____

Appropriately assertive _____
_____

States wants and needs _____
_____

Oriented to time and place _____
_____

Hyperactive _____
_____

Self-stimulatory behaviors _____
_____

Inappropriate sexual behavior _____
_____

Accepts responsibility for own actions _____
_____

VII. CRIMINAL HISTORY

Has applicant had any criminal charges or convictions? Yes No
If yes, please describe _____
_____
_____

VIII. MEDICAL HISTORY

1. Immunization Record. Please send copies.

Measles: Had measles or vaccinated with live measles vaccine since 1968 Yes No

Mumps: Had mumps or vaccinated with live vaccine after 12 months of age Yes No

Rubella: Had rubella or vaccinated after 18 months of age. Yes No

Tetanus & Diphtheria: Vaccinated first with a series of 3 doses (2^{nd} dose 4-8 weeks after 1^{st} dose, 3^{rd} dose 6-12 months after 2^{nd} dose); also a booster every ten years. Yes No

Polio: Series of Trivalent Oral Polio (OPV) vaccine at 2, 4 & 18 months of age; or if taken 4 doses of inactive polio vaccine (IPV), continue IPV every 6 years until 18 years of age. Yes No

Tuberculosis: Negative chest x-ray or Tine Test in past year. Yes No

2. Allergies

Is applicant allergic to foods, pollens, insect bites, skin contacts, substances, medicines, etc. Yes No

If yes, name allergy _____

If on medication/injection for allergies, give name of medication/injection, dose and frequency: _____
_____

3. Health History (Answer YES or NO to the following. If yes, explain in space provided. If extra space is needed, use separate piece of paper. Please send copy of physician's report.)

	Yes	No	Remarks
Heart Trouble	___	___	_____
Cold/Sinus Trouble	___	___	_____
Headaches	___	___	_____
Eyes	___	___	_____
Glasses	___	___	_____
Ears	___	___	_____
Hearing	___	___	_____
Chest Infection	___	___	_____
Asthma	___	___	_____
Epilepsy	___	___	_____
Tuberculosis	___	___	_____
Kidney Disease	___	___	_____
Stomach Trouble	___	___	_____

Diabetes	___	___	_____
Diarrhea	___	___	_____
Fainting Spells	___	___	_____
Menstrual Problems	___	___	_____
Muscle Problems	___	___	_____
Neurological	___	___	_____
Behavior Problems	___	___	_____
Psychiatric Problems	___	___	_____
Drug/Alcohol Abuse	___	___	_____
AIDS	___	___	_____

Is applicant on any regular medication? ___ Yes ___ No
If yes, name medicine, give dose and frequency: _____
_____

Name of Physician _____ Phone _____

Physician's Address _____

Has applicant had more than a brief illness during the past 3 years? Yes No

If yes, describe and give name and address of physician:_____
_____

Has applicant had any surgery in the past 3 years? ___ Yes ___ No

If yes, describe and give name and address of physician: _____
_____

Has applicant had a dental exam in the past 3 years? ___ Yes ___ No

Are applicant's teeth in good condition? ___ Yes ___ No
Please send dental records.

If there are other medical factors that would influence the care, health and well being of this applicant, please explain: _____
_____
_____
_____
_____

Is applicant able to self-medicate? ___ Yes ___ No
If the answer is no, please explain _____
_____

Does applicant require supervision to take medications? ___ Yes ___ No
If the answer is yes, please explain _____
_____

I affirm that the preceding information is, to the best of my knowledge and belief, a complete and true statement of facts and circumstances relative to this application.

_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Applicant (If appropriate)	Date
_____	_____
Signature of person filling out application if other than parent or guardian	Date

BEHAVIORAL QUESTIONAIRE

(to be completed for Residential Admission, DRI Camp, or Respite Care)

DRI (Disability Resources, Inc.) Camp and respite care are designed for individuals whose behavior is within acceptable guidelines. We cannot admit an applicant who has behavioral issues, and we may dismiss the individual if inappropriate behaviors occur. Such behaviors include but are not limited to:

Wandering, running away	Fighting
Refusal/inability to eat	Self-injurious behavior
Throwing objects	Refusal/inability to sleep
Emotional outbursts	Willful destruction of property
Biting, scratching, kicking	Incontinence of bowel/bladder

Please answer the following questions fully and feel free to explain anything you believe will help us ensure that he or she will enjoy and benefit from the services provided by DRI. Use space provided to add information, explain, or indicate current status. Please note that these questions are for evaluation to help assess an individual's general ability.

1. Has the applicant ever deliberately run or wandered away from a group he or she was supposed to stay with?
   _____Yes_____No_____

2. Has the applicant ever experienced a significant eating disorder, such as refusal or inability to eat, bulimia (induced vomiting after binging), or foraging for or stealing food?
   _____Yes_____No_____

3. Has the applicant indulged in emotional outbursts, rages, temper tantrums, willful destruction of property etc. in the past five years?
   _____Yes_____No_____

4. Has the applicant ever exhibited aggressive behavior toward another person, such as shoving, fighting, hitting, scratching, or biting?
   _____Yes_____No_____

5. Has the applicant ever exhibited self-injurious behavior, such as biting self, hitting self, head-banging, skin picking to injury, or anal picking?
   _____Yes_____No_____

6. Has the applicant ever gone through periods when he or she was unable to sleep through the night?
   _____Yes_____No_____

7. Has the applicant ever walked in his/her sleep?
   _____Yes_____No_____

8. Does the applicant mostly sleep all day and stay up all night?
   _____Yes_____No_____

9. Does the applicant exhibit foul language and cursing more than occasionally?
   ____ Yes_____No_____

10. Is the applicant incontinent for bowel or bladder?
    _____Yes_____No_____

11. Has the applicant ever been sent home from a camp or similar situation for reasons of behavior or general inability to adapt to camp life?
    _____Yes_____No_____

12. Does the applicant currently use tobacco products?
    _____Yes_____No_____

13. Has the applicant ever been hospitalized, arrested or detained in a mental health facility because of concern for injury toward self or others?
    _____Yes_____No_____

We cannot accept medically fragile individuals, or those who use G-tubes, feeding pumps, or baclofen pumps. We DO accept individuals who utilize wheelchairs.