DISABILITY RESOURCES, INCORPORATED
APPLICATION FOR ADMISSION
(Confidential)

Please complete the entire application and provide any applicable/requested supporting documents.

If you have any questions regarding this application, please contact our Residential Services Coordinator Kassie Wittkowski at 325-677-6815.

Once completed, please return the application via one of the following:

Email to info@driabilene.org

Mail to Disability Resources Inc.
Attn: Kassie Wittkowski
PO BOX 1880
Abilene, Texas, 79601

Fax to 325-673-7829.

Residential / Vocational Program

Date of Application: _____

Date of Placement Desired: _____

_____ _____
Applicant's Full Name Date of Birth

_____ _____ _____ _____
Street Address City State Zip Code

(___) _____ _____ _____ _____ _____

Shirt Size _____

Telephone Social Security # Height Weight Sex

Marital Status (check one): _____ Never Married _____Separated

_____ Divorced _____ Widowed _____ Married

I. ADVOCATE/GUARDIAN INFO

Contact's Name: _____ Relationship: _____

Home Address: _____ Zip: _____

Occupation & Name of Firm: _____

Home Phone: _____ Business Phone: _____

Email: _____

Contact's Name: _____ Relationship: _____

Home Address: _____ Zip: _____

Occupation & Name of Firm: _____

Home Phone: _____ Business Phone: _____

Email: _____

Religious Affiliation of Applicant: _____

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

_____

Please list two emergency contacts.

1. Name: _____ Phone: _____

   Address: _____ Zip: _____

2. Name: _____ Phone: _____

   Address: _____ Zip: _____

II. LEGAL STATUS

_____ Adult with Guardian or Person and Estate
_____ Adult with Guardian of Person only
_____ Adult with Guardian of Estate only
_____ Adult with Temporary Guardian

****Please enclose copy of legal guardianship papers if applicable. Please note that Guardianship is required for admission to Disability Resources. If there is no current guardian, please list who the guardian will be once established. **This must be completed within six months of admission.**

III. SCHOOLS OR PROGRAMS ATTENDED

1. High School: _____

   Date of Completion: _____

   Address: _____

   Person to contact for more information: _____

Please check all applicable arrangements and/or program in which the applicant has participated and complete the following information on each arrangement. Please use

additional pages if more space is needed. Disability Resources Inc. reserves the right to inquire any current and/or prior service agencies regarding the applicant. If you prefer we do not contact current and/or prior agencies, please provide an explanation below.

_____
_____
_____

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

2. Name: _____ Dates: _____

Address: _____

Type of arrangement (refer to above list): _____

Reason for leaving: _____

Person to contact for more information: _____

3. Name: _____ Dates: _____

Address: _____

Type of arrangement (refer to above list): _____

Reason for leaving: _____

Person to contact for more information: _____

IV. PERSONAL APTITUDE AND INTERESTS

Describe the applicant in relation to the following areas:
General Health: _____

_____

Peer Relationships: _____

_____

Daily Routine/Activities: _____

_____

Leisure Activities: _____

_____

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

_____

_____

Physical Limitations: _____

_____

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

_____

_____

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

_____

_____

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

_____

_____

V. SOCIAL BENEFITS

Please provide information regarding the applicant's current social benefits.

Is the applicant currently enrolled in Texas Medicaid? Yes No

If yes, what program type are they currently approved for? _____

Does the applicant receive any benefits from Social Security? Yes No

If yes, please select which program funds their benefit.

Social Security Disability Insurance (SSDI) Supplemental Security Income (SSI)
Social Security Retirement Income (SSRI) Social Security Survivors Benefits

Please provide the applicant's benefit amount awarded per month. Please provide the award letter from the Social Security Administration if possible. $_____

Is the applicant currently enrolled in Medicare? Yes No

Is the applicant currently enrolled with any other third party insurance provider? Yes No

If yes, please provide the third party insurance provider information below.

Insurance Provider: _____ Date Coverage Began: _____

Member ID: _____ Group ID: _____

Policy Holder's Name: _____

SSN of Policy Holder: _____

Birth Date of Policy Holder: _____

VI. FUNCTIONAL LIMITATION AREAS

A. **SELF CARE:** Please indicate whether the applicant can complete these daily tasks independently or not. If they cannot complete independently, please use the space below to provide information on the assistance they require.

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 self-care tasks. Yes No

B. **RECEPTIVE AND EXPRESSIVE LANGUAGE**: Some applicants need 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:** Some applicants need 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.

Does the applicant have any 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

D. **MOBILITY:** Some applicants need the assistance of another person or a mechanical device, or require 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

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

E. Self Direction – Some applicants need 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 – Some applicants need assistance when it comes to their emotional development.**

Needs help to routinely cope with fears, anxieties or frustrations.	Yes	No
Exhibits low self-esteem.	Yes	No
Demonstrates difficulty processing emotions.	Yes	No

- **Interpersonal/Family Relations – Some applicants needs help in establishing and maintaining relationships with family or peers**.

  Applicant lacks social maturity and awareness. Yes No

  Applicant is unable to protect self from exploitation. Yes No

- **Initiative – Some applicants need help to make independent decisions regarding daily schedules or time management.**
  Is the applicant able to manage personal finance. Yes No

  Delegate time appropriately for the task. Yes No

  Need assistance in scheduling activities or appointments. 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: Please answer the following regarding the applicant's capacity for independent living.

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

_____

_____

_____

_____

VII. BEHAVIORAL

Disability Resources Inc. is designed for individuals whose behavior is within acceptable guidelines. We cannot admit an applicant who has severe 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

If yes, please explain: _____

_____

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

If yes, please explain: _____

_____

3. Has the applicant indulged in emotional outbursts, rages, temper tantrums, willful destruction of property, etc. in the past five years? Yes No

If yes, please explain: _____

_____

4. Has the applicant ever exhibited aggressive behavior toward another person, such as shoving, fighting, hitting, scratching, hair pulling, screaming, use of excessive profanity or biting? Yes No

If yes, please explain: _____

_____

5. Has the applicant ever exhibited self-injurious behavior, such as biting self, hitting self, head banging, skin picking to injury, or pulling or plucking of their own hair?
Yes No

If yes, please explain: _____

_____

6. Has the applicant ever gone through periods when he or she was unable to sleep through the night? Yes No

If yes, please explain: _____

_____

7. Has the applicant ever walked in his/her sleep? Yes No

If yes, please explain: _____

_____

8. Does the applicant mostly sleep all day and stay up all night? Yes No

If yes, please explain: _____

_____

9. Does the applicant exhibit foul language and cursing more than occasionally?
Yes No

If yes, please explain: _____

_____

10. Is the applicant incontinent for bowel or bladder? Yes No

If yes, please explain: _____

_____

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

If yes, please explain: _____

_____

12. Does the applicant currently use any tobacco products? Yes No

If yes, please explain: _____

_____

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

If yes, please explain: _____

_____

14. How does the applicant typically respond to supervisors and/or other authoritative figures? _____

_____

15. How does the applicant typically respond to working and interacting with others?

_____

_____

****Due to Disability Resources Inc. not being a skilled nursing facility, there are limitations on the range of care we can provide medically. This will be determined on a case by case basis.**

Is the applicant appropriately assertive? Yes No

If no, please explain: _____

_____

Does the applicant state their wants and needs appropriately? Yes No

If no, please explain: _____

_____

Is the applicant oriented to time and place? Yes No

If no, please explain: _____

_____

Does the applicant display any hyperactive behaviors? Yes No

If yes, please explain: _____

_____

Does the applicant have any self-stimulatory behaviors such as humming, rocking, hand flapping? Yes No

If yes, please explain: _____

_____

Does the applicant have any inappropriate sexual behaviors? Yes No

If yes, please explain: _____

_____

Does the applicant accept responsibility for his or her own actions? Yes No

If no, please explain: _____

_____

Does the applicant have any past traumas and/or other significant life changing events?

Yes No

If yes, please explain: _____

_____

Does the applicant have any irrational fears? Yes No

If yes, please explain: _____

_____

VIII. CRIMINAL HISTORY

Has applicant had any criminal charges or convictions? Yes No

If yes, please describe: _____

_____

_____

IX. PSYCHO-EDUCATIONAL EVALUATIONS

1. Please include, with this application, copies of any available educational evaluations that have been given to the applicant.

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	___	___	_____	_____

X. MEDICAL HISTORY

1. Immunization Record. Please send copies.

   Shingles: Had shingles or vaccinated with shingles vaccine? Yes No

Chickenpox (Varicella): Had chickenpox or vaccinated with varicella vaccine? Yes No

Pneumonia: Has pneumonia vaccine within 5 years? Yes No

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

Covid: Any variation(s) of Covid Vaccines Yes No

If yes, please provide vaccination information for the vaccine received.

_____

Flu: Please also provide the approximate date of the last flu vaccination if applicable. Yes No Date _____

2. Allergies – If yes, please explain the type of reaction the applicant has as well as the severity of the reaction.

Is the applicant allergic to any foods? Yes No

If yes, please explain:

_____

_____

Is the applicant allergic to any medications? Yes No

If yes, please explain:

_____

_____

Is the applicant allergic to any insects? Yes No

If yes, please explain:

_____

_____

Is the applicant allergic to any environmental triggers? Yes No

If yes, please explain:

_____

_____

If on medication/injection for allergies, give name of medication/injection if available, dose, frequency, and rendering provider:

_____

_____

3. Does the applicant have any special medical needs and/or diagnoses? Yes No

If yes, please explain:

_____

_____

4. Describe any fine motor skills the applicant may struggle with.

_____

5. Health History (Answer YES or NO to the following for the APPLICANT. 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 Disease	___	___	_____
Cold/Sinus Trouble	___	___	_____
Headaches	___	___	_____
Eye Conditions	___	___	_____
(such as glaucoma, cataracts, etc.)			
Glasses	___	___	_____
Ears (tubes, etc.)	___	___	_____
Hearing	___	___	_____
(partial deafness, hard of hearing, wears aids, etc.)			
Pneumonia	___	___	_____
Bronchitis	___	___	_____
Asthma	___	___	_____
Epilepsy	___	___	_____
Tuberculosis	___	___	_____
Kidney Disease	___	___	_____
Chronic Stomach Ache	___	___	_____
Diabetes	___	___	_____
Chronic Diarrhea	___	___	_____
Fainting Spells	___	___	_____
Normal Menstrual Cycle	___	___	_____
Muscular Dystrophy	___	___	_____
Neurological	___	___	_____
Nerve Pain	___	___	_____
Drug/Alcohol Abuse	___	___	_____
AIDS	___	___	_____
Hypoglycemia	___	___	_____
BiPolar Disorder	___	___	_____
Anxiety	___	___	_____
Depression	___	___	_____
Cancer	___	___	_____
High Cholesterol	___	___	_____
High Blood Pressure	___	___	_____
Arthritis	___	___	_____
Lung Disease	___	___	_____
Thyroid Disease	___	___	_____

Heart Attack	___	___	_____
Diverticulitis	___	___	_____
Crohn's Disease	___	___	_____

If the applicant has glasses, does he or she wear them as directed? Yes No

If no, please explain:_____

_____

6. Health History (Answer YES or NO to the following for the applicant's FAMILY HISTORY. If yes, explain in space provided. Ex: maternal grandmother, paternal aunt, etc. If extra space is needed, use separate piece of paper.

	Yes	No	Remarks
Heart Disease	___	___	_____
Cold/Sinus Trouble	___	___	_____
Headaches	___	___	_____
Eye Conditions	___	___	_____
(such as glaucoma, cataracts, etc.)			
Glasses	___	___	_____
Ears (tubes, etc.)	___	___	_____
Hearing	___	___	_____
(partial deafness, hard of hearing, wears aids, etc.)			
Pneumonia	___	___	_____
Bronchitis	___	___	_____
Asthma	___	___	_____
Epilepsy	___	___	_____
Tuberculosis	___	___	_____
Kidney Disease	___	___	_____
Chronic Stomach Ache	___	___	_____
Diabetes	___	___	_____
Chronic Diarrhea	___	___	_____
Fainting Spells	___	___	_____
Normal Menstrual Cycle	___	___	_____
Muscular Dystrophy	___	___	_____
Neurological	___	___	_____
Nerve Pain	___	___	_____
Drug/Alcohol Abuse	___	___	_____
AIDS	___	___	_____
Hypoglycemia	___	___	_____
BiPolar Disorder	___	___	_____
Anxiety	___	___	_____
Depression	___	___	_____
Cancer	___	___	_____

High Cholesterol	___	___	_____
High Blood Pressure	___	___	_____
Arthritis	___	___	_____
Lung Disease	___	___	_____
Thyroid Disease	___	___	_____
Heart Attack	___	___	_____
Diverticulitis	___	___	_____
Crohn's Disease	___	___	_____

7. Medications

Is applicant on any regular medication? Yes No

If yes, name the medicine, state the reason for the medication, and give dose and frequency. Please be sure to include all vitamins, supplements, and over the counter medications.

Medication	Dose	Frequency	Reason for Taking

Name of Primary 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 treating physician:

  _____

- Has applicant had any surgeries? Yes No

If yes, describe procedure and provide approximate dates. Please include all procedures such as colonoscopy, EGD, hysterectomy, gallbladder removal, vasectomy, lasik, etc.

_____

_____

_____

- Has applicant had a dental exam in the past 3 years? Yes No
- Are applicant's teeth in good condition? Yes No
- Does the applicant have any artificial teeth, dentures, or veneers? Yes No

Please describe how the applicant responds/behaves at dental visits.

_____

_____

_____

***Please send dental records.**

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

_____

_____

_____

_____

8. Miscellaneous Medical History

Was the applicant born premature, full term, late, etc.?

_____

_____

Did the applicant meet childhood milestones timely or have any delays reaching them?

_____

_____

Does the applicant have any history of digestive issues or choking?

_____

_____

Does the applicant have any special needs or care consideration while eating?

_____

_____

Does the applicant have any adaptive equipment such as a CPAP, Bi PAP, hearing aid(s), cane, walker, wheelchair, plate guard, weighted utensils, etc.?

_____

_____

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 and the aforementioned applicant. Withholding information or providing inaccurate or misleading information regarding the applicant may result in denial for admission, discharge, and/or ineligibility for refund of fees.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Applicant (if appropriate) Date

_____	_____
Signature of person filling out application if other than parent or guardian	Date