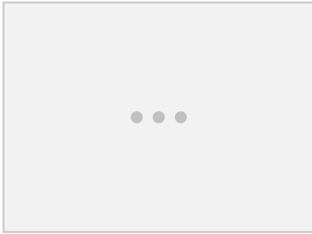

Admission Application
for Day Habilitation Services
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Section I - GENERAL INFORMATION

Full Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Home Phone: ______________ Cell Phone: ______________

Email Address: ______________________________

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 #: ____________________

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: __________ Cell: __________

Emergency Contact Name: ____

Address: ____

City, State, Zip: ____

Telephone: Home: ____________ Work: ____________ Cell: __________

Email Address: ____

Alternative Contact Name: ____

Address: ____

City, State, Zip: ____

Telephone: Home: ____________ Work: ____________ Cell: __________

Email Address: ____

Section II - FAMILY HISTORY

Mother: ▢Living ▢Deceased Date of Birth: ______________________

Full Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Employer: ______________________

Employer Address: ______________________

Telephone: Home: ____________ Work: ____________ Cell: ____________

Email Address: ______________________

Father: ▢Living ▢Deceased Date of Birth: ______________________

Full Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Employer: ______________________

Employer Address: ______________________

Telephone: Home: ____________ Work: ____________ Cell: ____________

Email Address: ______________________

Siblings:

Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Telephone(s): ______________________

Email Address: ______________________

Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Telephone(s): ______________________

Email Address: ______________________

Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Telephone(s): ______________________________

Email Address: ______________________________

Family Contact:

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

____

Family Medical History:

Condition	***Yes***	***No***	***Relation***	***Comments***
High Blood Pressure	▢	▢		
Heart Disease	▢	▢		
Kidney Disease	▢	▢		
GI Disturbances	▢	▢		
Blood Abnormalities	▢	▢		
Tuberculosis	▢	▢		
Epilepsy	▢	▢		
Diabetes	▢	▢		
Cancer	▢	▢		
Birth Defects	▢	▢		
Mental Retardation	▢	▢		
Psychiatric Disorder	▢	▢		
Chemical Dependency (i.e. tobacco, alcohol, drugs)	▢	▢		

Section III – MEDICAL PROFILE

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

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 per day, 1-2 per 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. _____

Attachments:
▢Copy of MassHealth 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
▢Signed Program Agreement
▢Media Release
▢Physician's Approval for Day Habilitation and Gym Equipment
▢MassHealth Permission to Share Information

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.