

APPLICATION FOR ADMISSION / Able Training Center

Name: _____ Date of Birth: _____
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Address: _____ Age: _____
 _____ Sex: _____

Phone #: _____

Hair Color: _____ Eye Color: _____ Race: _____

Height: _____ Weight: _____ Religion: _____

SSN: _____ Identifying Marks (scars, tattoos, etc.): _____

Name of Parent/Guardian/Emergency Contact: _____

Relationship: _____

Address: _____

Home Phone #: _____

Cell Phone #: _____

Email: _____

Preferred Method of Contact: Phone Text Email

Does anyone have legal guardianship of individual?: ___yes ___no

If yes, name of legal guardian: _____ (attach legal documentation)

Name of Supports Coordinator: _____

County: _____ BSU Number: _____

Funding Source for Day Programming: _____

Approved Staffing Ratio for Day Program: _____

Name of Primary Care Physician: _____

Address: _____

Phone #: _____

Medical Information

Level of Intellectual Functioning (mild, moderate, severe): _____

Diagnoses: _____

Date of Most Recent Physical Examination: _____

(If considered for admission, a current physical (within 1 year) will be required. It must include all up to date immunization records (Diphtheria/Tetanus within 10 years), a Tuberculin Test (within 2 years), and a statement that person is free of communicable diseases.)

Insurance Name: _____ Policy #: _____

Medicare Number: _____

Current Medications: – Include any occasionally used medication like Tylenol

*A prescription and/or standing order ***signed by a healthcare professional*** is required before we are permitted to administer medication at the day program.

Medication Name	Dosage	Time of Administration

Allergies (to drugs, food, other): _____

Special Diet (describe): _____

Sensory Issues: _____

Adaptive Aids or Equipment Needed: (please describe if yes)

Hearing Yes _____ No _____ _____

Vision Yes _____ No _____ _____

Mobility Yes _____ No _____ _____

Describe Level of Assistance Needed for the Following (independent, verbal prompting, physical prompting, total care/adaptive equipment, etc.):

Toileting: _____

Eating: _____

Ambulation: _____

Fire Safety: _____

Street Safety: _____

Hot Surfaces/Water: _____

Poisons/Non-Edibles Ingestion: _____

Daily Living Skills (cleaning, dressing, bathing, etc.): _____

Method of Communication (include example of verbalizations, tools/methods of communicating, language(s) spoken): _____

Behavioral Information

Describe any Challenging Behaviors (cussing, yelling, hitting, biting, throwing objects, property destruction, inappropriate touching, stealing, noncompliance, eloping, self-injurious behaviors, etc.): _____

Frequency of Challenging Behaviors: _____

Describe Triggers for Challenging Behaviors: _____

Best Way to Handle Challenging Behaviors: _____

Ability to be Left Unsupervised (length of time): _____

Educational Information

High School Name: _____ Date of Graduation: _____

List Individual's Interests, Hobbies, Leisure Activities: _____

Current Programming

Name of Current Day Program: _____

Describe Current Program Goals/Skill Development: _____

Why are you interested in coming to Able-Services' Day Program? _____

Additional Information

Other important information: _____

It is the policy of Leg Up Farm/Able-Services that we are a smoke free facility. Smoking anywhere on the premises – indoors or outdoors – is strictly forbidden. This includes the use of vaping systems and electronic cigarettes.

By submitting this application to be considered for admission, I understand that I will not be able to smoke *at any time* while in day programming at Able-Services. Additionally, I certify that the information contained in this application is true and accurate to the best of my knowledge.

Printed Name of Person Completing This Application

Signature of Person Completing This Application

Date

Additional Documentation Needed for Admission

- Most Recent Individual Service Plan (submit with application)
- Most Recent Psychiatric or Psychological Evaluation
- Physical Examination (must contain TB test and Immunization Records)
- Dr.'s prescription for all medication that will be taken during program hours (including OTC medications)
- Copy of Insurance Card(s)
- Legal Guardianship Documentation (if applicable)