Able-
SERVICES

Able-Services Program Application

Individual Applying to Receive Services		
First Name:	Middle Name:	Last Name:
Address:		Phone #:
		Email:
Is this address a residential program? _____ YES _____ NO		
If yes:	Agency Name:	Email:
	House Manager Name:	Phone #:
Date of Birth:	SSN:	Gender:
Medicaid #:	Race:	Hispanic/Latino?:
Height:	Weight:	Religion:
Hair Color:	Eye Color:	Language:
Characteristics/Identifying Marks (must list any scars, moles, birthmarks, missing teeth, tattoos, etc.):		
I would like to attend day programming: ____ 5 DAYS/WK _____ 4 DAYS/WK ____ 3 DAYS/WK ____ 2 DAYS/WK		
I would like to attend day programming on the following days (check all that apply): _____ MONDAYS _____TUESDAYS _____WEDNESDAYS _____THURSDAYS _____FRIDAYS _____ANY AVAILABLE		
Describe Method of Communication (ex. verbal, signs/gestures, iPad, etc.):		
Are Interpreter services necessary, due to limited English proficiency?: _____ YES _____ NO		
Supports Coordinator Name:		Email:
Funding Source (i.e. type of waiver):		
Does someone have legal guardianship (court ordered) of this individual? _____ YES _____ NO		
If Yes:	Guardian Name:	Relationship:
**Attach documentation*	Address:	
	Phone #:	Email:

Parent(s)/Relative(s)/Emergency Contact(s): ***please list in the order they should be contacted**		
First Name:	Last Name:	Relationship:
Address: ☐ Same as above		Phone #:
		Email:
First Name:	Last Name:	Relationship:
Address: ☐ Same as above		Phone #:
		Email:
Please list any other family members, providers, and/or service team members not already identified that should receive information regarding this individual (ex. siblings, residential staff, companion staff, behavior support specialists, etc.):		

Medical Information:		
Physician Name:	Medical Group Name:	
Address:		Phone #:
		Email:
Preferred hospital/health care group, in the event of an emergency:		
Diagnoses:		
Allergies and/or Contraindicated Medications:		
Will the individual take prescribed medications during program hours?: _____ YES _____ NO		
Can the individual self-administer medications? _____ YES _____ NO		
Does the individual have any sensory issues or concerns? _____ YES _____ NO		
If yes, please describe:		
Does the individual require any adaptive aids or equipment in the following areas?		
Hearing: _____ YES _____ NO *If yes, describe:		
Vision: _____ YES _____ NO *If yes, describe:		
Mobility: _____ YES _____ NO *If yes, describe:		
Other: _____ YES _____ NO *If yes, describe:		
Personal Needs, Behaviors, & Interests:		
Please describe the level of assistance needed in the following areas (ex. independent, prompting, total care):		
Eating:		
Does the individual follow a required special diet or have other eating guidelines? _____ YES _____ NO		
If yes, please describe:		
Toileting:		
Ambulation/Mobility:		
Fire Safety:		
Street Safety:		
Hot Surfaces/Water Temperature Regulation:		
Daily Living Skills (cleaning, dressing, bathing, etc.):		
Is the individual safe around poisons/non-edibles?: _____ YES _____ NO		
Please list the individual's likes, interests, hobbies, and leisure/recreational activities they enjoy:		
Please list things the individual dislikes, non-preferred activities, etc.		

Please describe any challenging behaviors exhibited by the individual (aggression, cussing, biting, property destruction, inappropriate touching, stealing, eloping, self-injurious behaviors, etc.):
How frequently are challenging behaviors displayed?:
Please describe any triggers for challenging behaviors:
Please describe the best way to handle challenging behaviors:
What skills would the individual like to work on at a day program? What community outings are they interested in?:
Signature and Certification:
My signature and submission certify that the information contained in this application is true and accurate to the best of my knowledge. I also understand that Able-Services is a smoke-free facility and no smoking, vaping, or electronic cigarette use is permitted during programming.
Name of Person Completing this Application:
Signature of Person Completing this Application:
Date:

Additional Documentation Required for Admission
- Most Recent Individual Service Plan (ISP) - Most Recent Psychiatric or Psychological Evaluation - Physical Examination (must have been completed within the last year) - TB Test (must have been completed within the last year) - Immunization Records - Dr.'s prescription for all medication that will be taken during program hours (including OTC medications) - Legal Guardianship Documentation/Court order (if applicable)