

Alleghany County Group Homes, Inc.  
**APPLICATION FOR ADMISSION**

**PERSONAL DATA**

Name: \_\_\_\_\_ Record Number: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of application: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Legal county of residence: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Color of Eyes: \_\_\_\_\_ Color of Hair: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Financial Support: Social Security \_\_\_\_\_; Medicaid \_\_\_\_\_; VA \_\_\_\_\_; Other \_\_\_\_\_

Case Manager's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parents: Father's name: \_\_\_\_\_

Address: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Maiden name: \_\_\_\_\_

Address: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital status of parents: \_\_\_\_\_

<u>Name of Siblings</u>	<u>Address</u>	<u>Phone</u>
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____

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**REFERRAL DATA**

Referral Source: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of Person Completing Application: \_\_\_\_\_

**GUARDIANSHIP AND NEXT OF KIN INFORMATION**

Type of guardianship: \_\_\_\_\_

County of Adjudication: \_\_\_\_\_ Date of Adjudication: \_\_\_\_\_

Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**CURRENT DIAGNOSES, DSM IV (Attach supporting documentation)**

	<u>NAME</u>	<u>NUMBER</u>
AXIS I	Diagnosis 1 _____	_____
	Diagnosis 2 _____	_____
AXIS II	Diagnosis 1 _____	_____
	Diagnosis 2 _____	_____
AXIS III	Diagnosis 1 _____	_____
	Diagnosis 2 _____	_____

Date of Last Psychological Evaluation: \_\_\_\_\_ Measured IQ: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date of Adaptive Behavior Evaluation: \_\_\_\_\_ Results: \_\_\_\_\_

Examiner: \_\_\_\_\_

Level of Adaptive Functioning: \_\_\_Mild \_\_\_Moderate \_\_\_Severe \_\_\_Profound

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**INDEPENDENT LIVING ABILITIES** (Check appropriate box)

- Ambulation:     Walks well             With difficulty             Uses walker  
                   Does not walk         Uses a wheel chair  
                   Crutches                 Cannot sit alone
- Dressing Skills:     Completely dresses self  
                           Completely dresses self with verbal prompt  
                           Pulls off or puts on clothes with help     Must be dressed
- Toileting Skills:     Never has accidents         Occasionally has accidents during day  
                           Occasionally has accidents during night  
                           Frequently has accidents during day     # day  
                           Is not toilet trained     Bedwetting         Frequency
- Bathing Skills:     Prefers shower         Prefers tub         Bathes independently  
                           Needs supervision to bathe     Needs partial assistance bathing  
                           Needs total assistance bathing
- Leisure Skills:     Entertains self             Needs direction from others
- Likes:     TV             Music         Outdoor activities  
                           Privacy     Groups       Sports         Swimming  
                           Movies      Games       Other \_\_\_\_\_

**SUPERVISION NEEDED**

- INDOORS:     Needs constant supervision     Can be left alone for up to \_\_\_\_\_  
OUTDOORS:     Needs constant supervision     Can be left alone for up to \_\_\_\_\_

**SOCIALIZATION**

- Initiates interaction with people         Initiates interaction selectively  
 Interacts with peers, staff, family         Interacts with staff, but not peers and family  
 Never, or rarely interacts with staff, peers and family

**EXPRESSIVE COMMUNICATION**

- Uses expressive language clearly     Initiates expressive language with difficulty  
 Uses expressive communication and gestures  
 Uses augmentative communication     Uses selective vocalizations  
 Uses ASL                                     Uses signs

**RECEPTIVE COMMUNICATION**

- Comprehends most spoken language     Comprehends little spoken language  
 Responds to gestures or auditory cues     attends to gestures or auditory cues  
 Does not respond to communication stimuli

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**SKILLS CHECKLIST** (If the applicant can perform these skills, fill in the corresponding block with a "Y" for yes and a "S" for sometimes. Leave blank for no.)

**SELF-HELP SKILLS**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Uses knife and fork correctly         | <input type="checkbox"/> Table manners are acceptable      | <input type="checkbox"/> Can serve his/her own food  |
| <input type="checkbox"/> Can pour liquids                      | <input type="checkbox"/> Can use knife for peeling/slicing | <input type="checkbox"/> Can order own food          |
| <input type="checkbox"/> Combs hair when needed                | <input type="checkbox"/> Keeps self clean                  | <input type="checkbox"/> Shaves self                 |
| <input type="checkbox"/> Shampoos hair                         | <input type="checkbox"/> Cuts own nails without prompt     | <input type="checkbox"/> Chooses appropriate clothes |
| <input type="checkbox"/> Changes underwear without prompt      |  | <input type="checkbox"/> Washes and dries clothing   |
| <input type="checkbox"/> Crosses road safely by self           | <input type="checkbox"/> Visits neighbors by self          | <input type="checkbox"/> Can care for minor injuries |
| <input type="checkbox"/> Knows how to obtain help in emergency |  | <input type="checkbox"/> Washes dishes, sets table   |
| <input type="checkbox"/> Cleans own room, picks up after self  |  | <input type="checkbox"/> Can cook simple things      |

**COMMUNICATION SKILLS**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Tells others about daily events | <input type="checkbox"/> Can answer telephone      | <input type="checkbox"/> Can make own calls   |
| <input type="checkbox"/> Can tell time correctly         | <input type="checkbox"/> Can keep appointments     | <input type="checkbox"/> Can write own name   |
| <input type="checkbox"/> Can write a letter              | <input type="checkbox"/> Reads simple instructions | <input type="checkbox"/> Reads menu, TV guide |
| <input type="checkbox"/> Reads newspaper                 | <input type="checkbox"/> Reads aloud to others     | <input type="checkbox"/> Can read price tag   |

**SOCIAL SKILLS**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Can read shopping list       | <input type="checkbox"/> Chooses own clothing         | <input type="checkbox"/> Can ask directions           |
| <input type="checkbox"/> Is friendly to others        | <input type="checkbox"/> Understands and uses stamps  | <input type="checkbox"/> Has good manners             |
| <input type="checkbox"/> Does not steal               | <input type="checkbox"/> Knocks on doors before entry | <input type="checkbox"/> Shares possessions           |
| <input type="checkbox"/> Works cooperatively in group | <input type="checkbox"/> Washes dishes, sets table    | <input type="checkbox"/> Follows directions willingly |
| <input type="checkbox"/> Can cook simple things       | <input type="checkbox"/> Saves money consciously      |   |

**COMMUNITY SKILLS**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Can give change for a quarter | <input type="checkbox"/> Can give change for dollar            | <input type="checkbox"/> Can use vending machine |
| <input type="checkbox"/> Can make small purchases      | <input type="checkbox"/> Can buy things on shopping list       | <input type="checkbox"/> Knows own clothing size |
| <input type="checkbox"/> Purchases own clothing        | <input type="checkbox"/> Asks sales clerk for items            | <input type="checkbox"/> Saves money consciously |
| <input type="checkbox"/> Can ask for directions        | <input type="checkbox"/> Uses public transportation unassisted |  |

**VOCATIONAL SKILLS**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Has good manual dexterity   | <input type="checkbox"/> Works cooperatively in group     | <input type="checkbox"/> Follows directions well |
| <input type="checkbox"/> Enjoys outdoor activities   | <input type="checkbox"/> Has hobbies                      | <input type="checkbox"/> Is on time by self      |
| <input type="checkbox"/> Works with little supervision   | <input type="checkbox"/> Works well with few mistakes     | <input type="checkbox"/> Corrects own mistakes   |
| <input type="checkbox"/> Realizes mistakes, stops work   | <input type="checkbox"/> Work done requires checking      | <input type="checkbox"/> Is usually on time      |
| <input type="checkbox"/> Usually on time with reminders  | <input type="checkbox"/> Careful with tools and equipment | <input type="checkbox"/> Careful when reminded   |
| <input type="checkbox"/> Works well with little supervision, but makes no effort to find a new job                   |   |  |
| <input type="checkbox"/> Is able to carry out several simple tasks with persistence and without constant supervision |   |  |

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

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**PHYSICAL HEALTH CARE NEEDS**

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Is Applicant currently under care of a doctor for any condition? \_\_\_ Yes \_\_\_ No

List illnesses or medical conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Seizures: \_\_\_ Yes \_\_\_ No Type and Frequency \_\_\_\_\_

List any medications for seizures: \_\_\_\_\_

Diet or regimen required? \_\_\_ Yes \_\_\_ No (Attach Copy)

**MEDICATIONS**

Name	Dosage & Frequency	Route	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SELF-ADMINISTRATION OF MEDICATIONS**

\_\_\_ Can take medications in right doses at right time \_\_\_ Can prepare and take medications with reminder

\_\_\_ Can take medications; needs help with preparation \_\_\_ Unable to take medication without assistance

Person responsible for assisting: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**VISION, HEARING AND DENTAL**

Normal     Sees with difficulty     Sees with great difficulty     Legally blind  
 Totally blind     Undetermined

Corrective Lenses?     Yes     No     Glasses     Contact lenses

Hearing:     Normal     Mild hearing loss     Moderate Hearing loss  
 Severe hearing loss     Profound hearing loss     Undetermined

Hearing aid?     Yes     No

Dental Appliances?     Yes     No

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BEHAVIORAL CONCERNS**

Does the applicant display any behaviors which are of concern to others?     Yes     No

If so, please rate all that apply as follows: 1 = severe; 2 = moderate; 3 = mild

<input type="checkbox"/> Self stimulation	<input type="checkbox"/> Assaultive behavior	<input type="checkbox"/> Stealing
<input type="checkbox"/> Loses temper easily	<input type="checkbox"/> Verbal threats	<input type="checkbox"/> Self-injurious behavior
<input type="checkbox"/> Property damage	<input type="checkbox"/> Excessive crying/screaming	<input type="checkbox"/> Non-compliance
<input type="checkbox"/> Lying	<input type="checkbox"/> Purposeful running away	<input type="checkbox"/> Aimless wandering away
<input type="checkbox"/> Inappropriate sexual behavior	<input type="checkbox"/> Eating of in-edibles	_____

Please explain all above rated behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other information that you would like us to know: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian or Legally Responsible Person: \_\_\_\_\_ Date: \_\_\_\_\_

Allegheny County Group Homes, Inc.: \_\_\_\_\_ Date: \_\_\_\_\_