Gateways to Better Living, Inc.
Admission Application

Referral for Admission:

I. Demographic Information

Name: Last:_____ First:_____ Middle:_____

Address:_____ City:_____ Zip:_____

Telephone:_____ County:_____

Birth Date:_____ Birth Place:_____

Sex: Male ☐ Female ☐ Race:_____ Religion:_____

SSA Name:_____ Phone:_____

Adopted: No ☐ Yes ☐ If yes: Year:_____ County/State:_____

Social Security #_____ Medicaid #_____ Medicare #_____

Medical Insurance: Agency:_____

Policy#:_____

MR Diagnosis: Mild ☐ Moderate ☐ Severe ☐ Profound ☐

MH Diagnosis: Please list any/all:_____

Type of Admission: ☐ ICF ☐ Supported Living ☐ Respite

Is this individual receiving waiver services? Yes ☐ No ☐

If 'yes' which waiver?_____

Waiver Provider Name?_____

If 'no', is he/she on a waiting list? Yes ☐ No ☐

Has this person been determined eligible for County Board Services? Yes □ No □ If yes, please attach supporting documentation. Name county of eligibility_____

If No, why not?_____

If determination has not been made, when is assessment planned?_____

Is this individual receiving any county board services? (ex: Day Program, SSA, Vocational, School Age)

Yes □ No □ If yes, please list service(s):_____

Is this individual involved with Children's Services? Yes ☐ No ☐ If yes, provide detail _____

_____

Does this individual have a Guardian? Yes □ No □ If yes, please provide the following guardian information:

Name: Last:_____ First:_____ Middle:_____

Address:_____ City:_____ Zip:_____

Telephone: (Home)_____(Work)_____(Cell)_____

Fax:_____ Email:_____

Relationship to Applicant:_____

Guardianship #_____ County Awarded:_____Date Established:_____

Secondary address or person to contact if guardian cannot be reached.

Name: Last:_____ First:_____ Middle:_____

Address:_____ City:_____ Zip:_____

Telephone: (Home)_____(Work)_____(Cell)_____

Email:_____ Relationship to Applicant:_____

II. Residential Placement History

Beginning with the individual's current residence, please provide the following information for each place the individual has lived.

1. Current Residence – From _____ to current

Contact:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Lives with: ☐Family (List)_____

☐Alone ☐With Room/Housemates (how many)_____

☐DODD licensed facility (Name of Facility)_____

☐Other – please provide detail _____

What are the positive aspects of this experience?_____

What are the negative aspects of this experience?_____

What has changed and/or why is this option no longer possible for the applicant?_____

_____

2. Current Residence – From _____ to _____

Contact:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Lives with: ☐Family (List)_____

☐Alone ☐With Room/Housemates (how many)_____

☐DODD licensed facility (Name of Facility)_____

☐Other – please provide detail _____

What are the positive aspects of this experience?_____

What are the negative aspects of this experience?_____

What has changed and/or why is this option no longer possible for the applicant?_____

_____

3. Current Residence – From _____ to current

Contact:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Lives with: □Family (List)_____

□Alone □With Room/Housemates (how many)_____

□DODD licensed facility (Name of Facility)_____

□Other – please provide detail _____

What are the positive aspects of this experience?_____

What are the negative aspects of this experience?_____

What has changed and/or why is this option no longer possible for the applicant?_____

_____

III. Medical Information

Current Height_____ Weight_____ Ambulatory: Yes ☐ No ☐

Food allergies_____

Medication allergies_____

Non-food allergies_____

List any **major injuries and/or illnesses** – include date(s)_____

_____

Does the applicant have seizures?_____ If yes, please describe_____

Are seizures associated with any condition?_____ If yes, please list & provide any detail _____

_____

List all **current medications,** dosage, frequency and related diagnosis. (Attach additional pages if necessary)

_____

_____

List any **surgeries and/or hospitalizations –** provide dates and causes _____

_____

Has the applicant had any **sexually transmitted disease? _____ If yes,** list when, treatment and physician

_____

List **dietary** needs/orders, include any specific likes/dislikes, allergies/sensitivities, calories or texture requirements_____

_____

List any adaptive/assistive equipment_____

Medical needs that require nursing care_____

1. **Current Primary Physician**_____
   Address:_____
   City_____ State:_____ Zip:_____
   Telephone:_____
   Date last seen:_____
2. **Current Dentist**_____
   Address:_____
   City_____ State:_____ Zip:_____
   Telephone:_____
   Date last seen:_____
3. **Current Psychologist**_____
   Address:_____
   City_____ State:_____ Zip:_____
   Telephone:_____
   Date last seen:_____
4. **Other physicians (ex. Audiologist, Psychiatrist, Neurologist, etc.) List and provide name, address and phone number:**_____

   _____

Advanced Directives: DNR Yes ☐ No ☐ **DNRCC:** Yes ☐ No ☐ If yes, attach documentation

Check if the applicant has had any of the following:

Pleurissy ☐ Diabetes ☐ Diphtheria ☐ Malaria ☐ Venereal Disease ☐
Meningitis ☐ Pneumonia ☐ Typhoid fever ☐ Scarlet Fever ☐ Rheumatic Fever ☐
Chicken Pox ☐ Hepatitis B ☐ Broken Bones ☐

Immunization Record (Provide Dates)

DPT_____ Polio_____ Flu_____ Pneumonia____ Small Pox____ Tetanus Booster____
Measles____ Mumps____ Rubella_____ Chicken Pox____ Hepatitis B Antibody____
Hepatitis B vaccine (series of 4)_____ PPD____

IV. Family Information

Father: Last:_____ First:_____ Middle:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____

Social Security #:_____ Birth Date:_____ Place of Birth:_____

Occupation:_____ Employer:_____

Veteran: No ☐ Yes ☐ If Yes, Branch:_____ Veteran #_____ Dates_____ to _____

Health:_____

If deceased, date:_____

Involvement:_____

Mother: Last:_____ First:_____ Middle:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____

Social Security #:_____ Birth Date:_____ Place of Birth:_____

Occupation:_____ Employer:_____

Veteran: No ☐ Yes ☐ If Yes, Branch:_____ Veteran #_____ Dates_____ to _____

Health:_____

If deceased, date:_____

Involvement:_____

Siblings/other involved family members

Relationship:_____

Last:_____ First:_____ Middle:_____

Address:_____ City/State:_____ Zip:_____

Telephone:_____

Involvement:_____

Relationship:_____

Last:_____ First:_____ Middle:_____

Address:_____ City/State:_____ Zip:_____

Telephone:_____

Involvement:_____

Family Medical History: Check all that has affected parents, brothers, sisters, blood relatives

☐Cancer	☐Anemia, Leukemia, Blood Disorder	☐Heart Disease
☐Tuberculosis	☐Epilepsy	☐Muscular Dystrophy
☐Multiple Sclerosis	☐Central Nervous System/Brain Tumor	☐Alcoholism
☐Rheumatoid Arthritis	☐Kidney or Bright Disease	☐Meningitis
☐Gout	☐Parkinsonism	☐Drug Abuse
☐Mental Health Disorders	☐Other:_____	

V. Financial Information:

Social Security Claim (SSA):……#_____ Amount:$___

Supplemental Security Income (SSI) #_____ Amount:$_____

Veteran Administration (VA):……..#_____ Amount:$_____

Railroad:……#_____ Amount:$_____

Teacher / PERS……#_____ Amount:$_____

Police……#_____ Amount:$_____

Other……#_____ Amount:$_____

Payee Information:

If admitted would you approve Gateways as payee ☐ Yes ☐ No

Name: Last_____First:_____Middle:_____

Address:_____ City:_____Zip:_____

Telephone: (Home)_____ (Work)_____

Insurance Coverage:

Life……..Company:_____ Policy #:_____

Owner:_____ Amount: $_____

Health……. Company:_____ Policy #:_____

Accident/disability……. Company:_____ Policy #:_____

Pre-Arranged Burial Plans: Where is the burial document located? (Please provide a copy upon admit)

Funeral Home:_____ City:_____

Cemetery:_____ Lot #:_____

Specific requests:_____

VI. Education: List schools currently attending or attended (include district or city). List dates and indicate if regular or special classes. List the current or most previously-attended school first.

1._____

2._____

VII. Employment and/or Day Programming: List all work experience. Include dates and whether sheltered or competitive. List the current employer first and provide the name and phone number of someone to contact.

1._____

2._____

3._____

Would you be interested in learning more about Gateways Industries? ☐ Yes ☐ No

VIII. **<u>Behavior/Emotional:</u>** - Describe the applicant's **relationships** with:

Father:_____

Mother:_____

Siblings:_____

Teacher/work supervisior:_____

Peers:_____

Others:_____

Describe anything that interferes with the applicant's **social/occupational functioning** (ex. Behaviors, communication, physical limitations)_____

_____

Describe hobbies, special interests, favorite activities_____

Describe any problems/concerns related to **smoking, drug or alcohol use, agitation, aggression, self injury, sexuality, etc.**_____

_____

List any **police and/or court contact;** include dates and brief descriptions of each contact._____

_____

List any **current or pending criminal and/or court hearings/judgements.**_____

_____

Found Competent: ☐ Yes ☐ No If yes, list date(s)_____

Current Behavior issues:_____

Behavior plan: ☐ Yes ☐ No Attach current plan

IX. **<u>Safety:</u>**

Is this individual an elopement risk? ☐ Yes ☐ No If yes, provide details/examples_____

_____

Does this individual pose a safety risk to him/herself or others? ☐ Yes ☐ No If yes, please provide details

_____

Identify how the person may be vulnerable in the community without supervision._____

_____

What are the risks to the community if the person is unsupervised?_____

_____

Are there frequent places or types of places this person may go when left unattended in the community?

_____

Please list any important information not already included in this referral/pre-application.

_____

To complete the referral/pre-admission application the following documentation must accompany the completed application:

(1) The most recent psychological evaluation or update

(2) Immunization records (TB, Rubella, Polio, Tetanus, Hep B, Pertussis, Diphtheria, Influenza, Pneumonia)

(3) Previous Level of Care, if applicable

(4) Copy of guardianship papers, if applicable

(5) Copy of current habilitation plan, if applicable

(6) Copy of current behavior plan, if applicable

(7) Copy of Medicaid card

(8) Copy of Social Security card

(9) Copy of birth certificate

(10) Release of Authorization for specific medical or other information

(11) Copy of Life Insurance Policy, if applicable

(12) Copy of Burial Contract, if applicable

(13) Appropriate medical records including <u>current</u> medications, most recent physical exam, and psychiatric diagnosis.

(14) Copy of OEDI

X. <u>Sources of Information:</u>

Informant:

Name: Last:_____ First:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone:_____ Relationship to Applicant:_____

Completed by:

Name (print):_____

Agency:_____ Title:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone:_____ Fax:_____ Email:_____

I understand that the information provided in this document will be used by Gateways to Better Living, Inc. to evaluate whether the referred individual is appropriate for placement into the agency. I understand that Gateways may offer technical assistance and consultation to the referring entity prior to any admission. Any admission to Gateways is considered a temporary placement and subject to receiving all available information as requested.