Westbank ARC

Application for Day Habilitation Services

Date of Application _____

Name (Client) _____
Last Name First Name Initial

Present Address _____
Street

_____
City State Zip Code

Telephone ( ) _____ Cell ( ) _____

Social Security No. _____ Medicaid# _____ Medicare#: _____

Insurance: _____ Policy #: _____

Hospital of Choice: _____

Date of Birth: _____ Age: _____ Religion: _____

Gender ☐ Male ☐ Female

Marital Status: (Check One)

- ☐ Single
- ☐ Married
- ☐ Do not know

Legal Status of Applicant

- ☐ Competent Major
- ☐ Interdicted

Referral Source

How did you learn about WBARC?

- ☐ Case Manager
- ☐ LRS Counselor
- ☐ JPHSA Case Worker
- ☐ Freedom of Choice List
- ☐ Other

How would you characterize the place where this person lives? (check one)

- ☐ Specialized institutional facility for persons with MR/DD (ICFs/MR)
- ☐ Group Home
- ☐ Agency-operated apartment type setting
- ☐ Independent home or apartment
- ☐ Parent/ relative's home
- ☐ Other Specify: _____

DISABILITIES

How is person diagnosed in records? (Check one)

- ☐ Does not have Mental Retardation Label
- ☐ Mild Mental Retardation
- ☐ Moderate Mental Retardation
- ☐ Severe Mental Retardation
- ☐ Profound Mental Retardation
- ☐ Do not know or unspecified in records

What disabilities other than MR are noted in this person's records? (Check all that apply)

- ☐ Mental Illness/ Psychiatric diagnosis
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Schizophrenia
  - ☐ Other (Please Specify)

_____

_____

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Brain Injury
- ☐ Seizure disorder/ neurological problem
- ☐ Chemical dependency
- ☐ Vision or hearing impairment
- ☐ Physical disability
- ☐ Communication disorder
- ☐ Alzheimer's disease
- ☐ Other (Please Specify)

_____

_____

- ☐ Do not know or unspecified in records

What is this person's primary means of expression?

- ☐ Speaks English
- ☐ Speaks other primary language (Please specify)

_____

- ☐ Uses gestures
- ☐ Uses sign language or finger spelling
- ☐ Uses communication device
- ☐ Other (Please specify)

_____

- ☐ Do not know

How would you describe this person's mobility?

- ☐ Walks (with or without aids)
- ☐ Non-ambulatory
- ☐ Do not know

How would you describe this person's vision?

- ☐ Sees well, with or without corrective lenses
- ☐ Vision problems limit activities, such as reading or travel
- ☐ Do not know

How would you describe this person's hearing?

- ☐ Normal in both ears
- ☐ Deficit in left ear
- ☐ Deficit in right ear

Health

How many days in the past month has this person's normal routine been interrupted because he/ she was sick?
(i.e. person did not go to work, school, day program or their scheduled activity outside the home due to being sick)
___ ___ ___ Number of days

Medication

List Medications and Dosages

Medication	Dosage	Time/s	Purpose

If this person has seizures, how often do they occur? (check one)

- ☐ Not Applicable Does not have seizures
- ☐ Less than once/ month
- ☐ Once/ month
- ☐ Once/ week
- ☐ More than once/ week
- ☐ Do not know

How would you describe the person's seizure?

- ☐ Grand Mal
- ☐ Petit Mal

What does the seizure look like?

- ☐ Stare Blankly
- ☐ Falls to the ground
- ☐ Other (Please describe)

_____

_____

When was the person's last physical exam?

- ☐ Within the past year
- ☐ Over one year ago
- ☐ Do not know

Does person have any back problems?

- ☐ Yes Describe:

_____

_____

- ☐ No

Does the person have diabetes?

- ☐ Yes
- ☐ No

Does the person have any dietary restrictions? If so explain.

Does the applicant have any allergies? If so explain.

Education History

Name of School and Address	No.of Yrs.	Course or major	Diploma/ Degree

Sheltered Employment

As the person participated in a Day Habilitation Program?

Name of Program Address Phone Number	Dates of Attendance	Reason for Leaving

Learning and Performance Characteristics

Communication

What is the main way that the client communicates? (Check One)

- ☐ Uses Sounds/ Gestures
- ☐ Uses Key Words
- ☐ Speaks Unclearly
- ☐ Communicates Clearly

Social Interaction Skills

How frequently does the person initiate conversation or interaction?

- ☐ Rarely Interacts Appropriately
- ☐ Polite & Appropriate
- ☐ Initiates Interactions Infrequently
- ☐ Initiates Frequently

How does the person learn things the best? (Check one)

- ☐ Verbal Instruction
- ☐ Modeling from someone else
- ☐ Gestures

What is the client's reinforcement needs? (Check one)

- ☐ Frequent Reinforcement
- ☐ Daily
- ☐ Weekly

Rate the person for handling criticism/ stress. (Check one)

- ☐ Resistive/ Argumentative
- ☐ Withdraws Into Silence
- ☐ Accepts Criticism/ Does not Change
- ☐ Accepts Criticism to grow

Does the person adapt to changes in schedule?

☐ Yes ☐ No

At what pace can the person do activities?

☐ Slow ☐ Average ☐ Sometimes Fast ☐ Continual Fast

What does the person adapt/ adjust to the best?: (Check only one)

- ☐ Small Area Only
- ☐ One Room
- ☐ Building Wide
- ☐ Building and Grounds
- ☐ Comfortable in the whole community

Can the person cross the street?

☐ Yes ☐ No

What chores does is the person responsible for at home?

Picking-up Clothes?

☐ Yes
☐ No

Clean Dishes?

☐ Yes
☐ No

Vacuum?

☐ Yes
☐ No

Sweep?

☐ Yes
☐ No

Do you mow the lawn?

☐ Yes
☐ No

Frequency of Problem Behaviors

Self-Injury:

Does the person ever cause injury to him/ herself ex. Hitting, self, biting, banging head, scratching or puncturing skin.

- ☐ Yes
- ☐ No
- ☐ Do not know

If yes, about how often does the behavior occur? (check one)

- ☐ less than once/ month
- ☐ 1-3 times/ week
- ☐ 1-6 times/week
- ☐ 1-10 times/ day
- ☐ one or more time/ hour

Disruptive Behavior:

Does the person ever interfere with the activities of others? Ex. Starting fights, laughing or crying without reason, yelling or screaming?

- ☐ Yes
- ☐ No
- ☐ Do not know

If yes, about how often does the behavior occur?

- ☐ less than once/ month
- ☐ 1-3 times/ week
- ☐ 1-6 times/week
- ☐ 1-10 times/ day
- ☐ one or more time/ hour

Uncooperative Behavior:

Does this person ever engage in 'uncooperative' behavior? Ex. Breaking rules or laws, cheating, acting defiant, or stealing?

- ☐ Yes
- ☐ No
- ☐ Do not know

If yes, about how often does the behavior occur?

- ☐ less than once/ month
- ☐ 1-3 times/ week
- ☐ 1-6 times/week
- ☐ 1-10 times/ day
- ☐ one or more time/ hour

Does person generally throw objects when angered?

- ☐ Yes
- ☐ No
- ☐ Do not know

If yes, about how often does the behavior occur? (check one)

- ☐ less than once/ month
- ☐ 1-3 times/ week
- ☐ 1-6 times/week
- ☐ 1-10 times/ day
- ☐ one or more time/ hour

Does person generally hit others when angered?

- ☐ Yes
- ☐ No
- ☐ Do not know

If yes, about how often does the behavior occur? (check one)

- ☐ less than once/ month
- ☐ 1-3 times/ week
- ☐ 1-6 times/week
- ☐ 1-10 times/ day
- ☐ one or more time/ hour

Applicant/ Client lives with: (Please list who lives in the household currently)

Name	Relationship	Age

Parent/ Guardian: (Mother)

Name:_____ Relationship: _____

Address:_____

_____

Phone:_____ Beeper:_____

Work Phone:_____ Cell:_____

Parent/ Guardian: (Father)

Name:_____ Relationship: _____

Address:_____

_____

Phone:_____ Beeper:_____

Work Phone:_____ Cell:_____

Emergency Contact 1: (Not living in the home: friend, relative etc.)

Name:_____ Relationship: _____

Address:_____

_____

Phone:_____ Beeper:_____

Work Phone:_____ Cell:_____

Emergency Contact:

Name:_____ Relationship: _____

Address:_____

_____

Phone:_____ Beeper:_____

Work Phone:_____ Cell:_____

Emergency Contact:

Name:_____ Relationship: _____

Address:_____

_____

Phone:_____ Beeper:_____

Work Phone:_____ Cell:_____

Interviewer Comments

_____

_____

_____

_____

_____

_____ _____

Signature of Applicant/ Client **Date**

_____ _____

Signature of Guardian/ Parent **Date**