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ADMISSION APPLICATION

Applicant's Name: _____

Full Address: _____

Phone Number where you can be reached at: _____

Does the applicant have a guardian? No Yes (If yes, attach a copy of the guardianship papers)

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____

Age: _____ Sex: Male Female Birthdate: _____

Referred By:

Name: _____

Relationship: _____ Phone: _____

Agency: _____

DEVELOPMENTAL DISABILITY

Neurological handicap Cerebral palsy Other: _____

Does the individual requesting service's have waived services through DDSD? No Yes

REQUESTED SERVICES

Residential

Supportive Living Community Based In-Home Supports Traditional Group Home Community Group Home

Employment

Workshop Center Based Community Job Coach Community Integrated Employment

OTHER AGENCY INVOLVEMENT

Agency Name	Dates	Type of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY INFORMATION

Medical Insurance: Medicaid Medicare Private (who)

What hospital should be used in case of an emergency? _____

Primary Physician's Name: _____ Phone: _____

Full Physician's Address: _____

Emergency contact: _____

Phone: _____ Relationship: _____

MEDICAL INFORMATION

Does the applicant take medicine? No Yes (if yes, attach a list with reason prescribed)

Does the applicant have seizures? No Yes (if yes, how severe)

Has applicant ever been hospitalized or had surgery? No Yes

If yes, give approximate dates and explain: _____

List any medication or food allergies: _____

WORK HISTORY

Has applicant worked before? No Yes (List job abilities)

BACKGROUND INFORMATION

Has applicant ever been convicted of a criminal misdemeanor or felony? No Yes

If yes, give type of offense(s), dates and disposition of case(s): _____

Reason for seeking placement: _____

APPLICANT CHARACTERISTICS

Vision: Normal Impaired Glasses Blind
 Hearing: Normal Impaired Aids Deaf
 Speech: Normal Impaired Device Assistance
 Feeding: Independent Prompts Assistance needed
 Toileting: Independent Prompts Assistance needed
 Ambulation: Independent w/ Support Assistance needed

NEGATIVE BEHAVIORS

	No	YES (describe)
Threatens or does physical violence to self or others	<input type="checkbox"/>	_____
Damages own or others property	<input type="checkbox"/>	_____
Disrupts others activities	<input type="checkbox"/>	_____
Uncooperative	<input type="checkbox"/>	_____
Runs away	<input type="checkbox"/>	_____
Takes others property	<input type="checkbox"/>	_____
Maladaptive sexual behavior	<input type="checkbox"/>	_____
Hyperactive	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	_____
Illegal Drugs	<input type="checkbox"/>	_____

Signature of applicant or person completing application/Date

If accepted for services, INCOR will need the following:

Oklahoma ID Card/Drivers License	Social Security Card	Medicaid/Medicare Card
Birth Certificate	Shot Record	Guardianship Papers

~~~~~**OFFICE USE ONLY**~~~~~

Date Application Received: \_\_\_\_\_ Received By: \_\_\_\_\_

Date Approved for Services: \_\_\_\_\_ Approved By: \_\_\_\_\_

Date Services Start: \_\_\_\_\_ Location of Services: \_\_\_\_\_

Is Transportation needed: \_\_\_\_\_ Start Date for Transportation: \_\_\_\_\_



NEW INDIVIDUAL INFORMATION

**Name:** \_\_\_\_\_ **INCOR ID:** \_\_\_\_\_  
(OFFICE USE ONLY)

**DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**POC Dates:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

**Type of Waiver:** \_\_\_\_\_ **Type of Program:** \_\_\_\_\_

**Full Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Ethnicity:** \_\_\_\_\_ **Consumer ID:** \_\_\_\_\_

**Ambulatory:** \_\_\_\_\_ **Ambulatory w/ assistance:** \_\_\_\_\_ **Walker:** \_\_\_\_\_ **Non-Ambulatory:** \_\_\_\_\_

**Start Date for Transportation:** \_\_\_\_\_ **(OFFICE USE ONLY)**  
**Monthly Charge:** \_\_\_\_\_

**Guardian:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Full Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email address:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Payee:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Full Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email address:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Parent:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Full Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email address:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

IF THE INDIVIDUAL HAS A GUARDIAN, A COPY OF THE GUARDIANSHIP PAPERS WILL BE NEEDED TO FILE IN THEIR BOOK. IF NO GUARDIANSHIP PAPERS THEN DOCUMENT N/A.

**FILL IN ALL BLANKS.**

Routing: Accounting  
Data Entry