



ADMISSION APPLICATION

Applicant's Name: \_\_\_\_\_

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

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

Name of involved relative: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Does the applicant have a guardian?  No  Yes (If yes, list name and relation)

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Race: \_\_\_\_\_

Distinguishing Marks: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female Birthdate: \_\_\_\_\_

How did you hear about us?

Friend \_\_\_\_\_  Yellow Book Ad  Other \_\_\_\_\_

Agency \_\_\_\_\_  Internet \_\_\_\_\_

DEVELOPMENTAL DISABILITY

Neurological handicap  Cerebral palsy  Other: \_\_\_\_\_

Does the individual requesting service's have waived services through DDS?  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

Table with 3 columns: Agency Name, Dates, Type of Service. Includes three empty rows for data entry.

EMERGENCY INFORMATION

Medical Insurance:  Medicaid  Medicare  Private (who)

What hospital should be used in case of an emergency? \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Psychologist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Psychiatrist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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)

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

Any medical concerns  No  Yes (If yes, 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): \_\_\_\_\_

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

List any Specialized Instructions: \_\_\_\_\_

\_\_\_\_\_

**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"/>	
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 admitted we will need a copy of the following:**

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