COMMUNITY MAINSTREAMING ASSOCIATES, INC.

Helping Extraordinary People Lead Ordinary Lives

99 Quentin Roosevelt Boulevard, Suite 200
Garden City, New York 11530
Phone: 516-683-0710
Fax: 516-683-0718

APPLICATION FOR RESIDENTIAL SERVICES

Date: _____

Name of Applicant: _____

DOB: _____ **Home Telephone:** _____

Address: _____

_____

Father's Name: _____ **Business Phone:** _____

Mother's Name: _____ **Business Phone:** _____

Parent's address (if different from applicant)**:**

_____

_____

Does the applicant have a legal guardian? _____Yes _____No

Is Applicant on New York Cares Waiting List? _____ **TABS#** _____

Applicant's Medicaid# _____

Applicant's Social Security# _____

If applicant does not have Medicaid or Social Security numbers, have these been applied for? _____Yes _____No
Does applicant receive SSI? _____Yes _____No
Does applicant receive SSD? _____Yes _____No

Is applicant enrolled in the Home and Community Based Services Waiver_____
If yes, you must include a copy of the Notice of Decision (NOD) with this application.

Emergency Contact Information (please complete all information)**:**

Name	**Relationship**	**Address**	**Phone**

_____

_____

Educational Background

School(s)/Training Programs **Grade Completed** **Date Attended**

1. _____

2. _____

3. _____

Employment Background

Has applicant ever received any job or vocational training? _____Yes _____No
(If yes, please list below)

Place of Employment **Position** **HRS/Wk** **Salary** **Dates**
(Name and Address)

1. _____
2. _____
3. _____

References

Name **Address** **Phone**

1. _____

2. _____

3. _____

Please indicate below any residential facilities the applicant may have attended:

Facility **Dates** **Reason for Leaving**

1. _____

2. _____

3. _____

Has applicant ever been denied admission or involuntarily discharged from a residential facility? _____ Yes _____No If yes, please explain: _____

_____

_____

Medical History

What is applicants primary diagnosis: _____ IQ: _____

Was diagnosis received prior to age 21? _____yes _____no

Secondary Diagnosis: _____

If applicant is currently under the care of the follow medical doctors, please list:

1. Personal Physician or Clinic

Name: _____

Address: _____

_____

Phone #: _____

Hospital Affiliation: _____

Date of Last Visit: _____

2. Dentist or Clinic

Name: _____

Address: _____

_____

Phone Number: _____

Date of Last visit: _____

3. Gynecologist or Clinic

Name: _____

Address: _____

_____

Phone # _____

Date of Last Visit: _____ Date of last PAP smear: _____

4. Neurologist

Name: _____

Address: _____

_____

Phone #: _____

Date of last visit: _____

5. Please list name and addresses of other physicians applicant may see on a regular basis:

Name	Address	Specialty	Date last visited
1.			
2.			
3.			

6. Is applicant receiving medication regularly? _____yes _____no If yes, please list medication, dosage prescribing physician and reason prescribed.

Medication	Dosage	Prescribing Physician	Reason
1.			
2.			
3.			
4.			
5.			

7. Does applicant self-administer medication? _____yes _____no If no, briefly detail who administers medication:

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8. Has applicant ever been admitted to a psychiatric hospital or a psychiatric ward in a general hospital? _____yes _____no If yes, please list hospital(s), date(s) of admission and length of hospitalization.

Name of Hospital	Date of Admission	Length of hospitalization

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9. Do you consider applicant to be in good emotional or mental health?

_____ yes _____no Please explain: _____

_____

_____

10. Does applicant experience seizures at present time? _____yes _____no

a) If yes, please describe how it is manifested and type of seizures (grand mal, petit mal, psychomotor, etc.)_____

_____

b) How frequently do seizures occur? _____

c) What medication(s) does applicant take to control seizures?

_____

d) Is applicant usually aware when a seizure is to occur? _____yes _____no
If yes, describe aura: _____

_____

11. Has applicant experienced seizures in the past? _____yes _____no
If yes, specify type and date of late seizure _____

_____

12. Does applicant have allergies to medicine or other allergies?
_____yes _____no If yes, please complete below:

Allergy	**Controlling medication (if any)**

13. Has applicant ever experienced a negative or toxic reaction to medication?
_____yes _____no If yes please explain: _____

14. Does applicant require any adaptive technology? _____yes _____no
If yes, please specify technology and purpose below:

Adaptive technology	**Purpose**

15. Is applicant in good health overall? _____yes _____no
If no, please explain: _____

Social/ADL Skills

1. Does applicant belong to any social organizations or recreational programs?
_____yes _____no If yes please specify: _____

2. Generally, how does applicant spend leisure time? _____

3. Religious affiliation (if any): _____

4. Anticipated problems with adjustment to residence: _____

5. Please check one for each of the following:

Does applicant:

	Independently	**Usually needs to be reminded**	**Only with direct supervision**
1.Brush teeth daily			
2. Shower/wash hair			
3. Dress appropriately			
4. Maintain clean/neat room			
5. Tend to personal laundry			
6. Partake in household chores			
7. Take care of menstruation			

Does applicant:

	Yes	No	Needs help
1. Travel alone in the community			
2. Stay alone in residence			
3. Take a bus alone			
4. Travel by Taxi alone			
5. Travel by train alone			
6. Exit at the sound of fire alarm			
7. Schedule own medical appointments			
8. Attend appointments alone			
9. Acquire and renew medication independently			
10. Take medication independently			
11. Write their name			
12. Use the telephone			
13. Simple math (addition/subtraction)			
14. Read and write other than name			
15. Buy personal items for self			
16. Prepare a simple meal			
17. Comprehend and tell time (digital or analog)			
18. Comprehend basic money concepts			
19. Cash check at bank			
20. Manage a savings account			
21. Totally manage personal finances			

In general, how does applicant:

	Maturely/ appropriately	Usually appropriately	Often appropriately	Resistant or needs improvement
1. Respond to supervision				
2. Relate to peers				
3.Accept structure				
4. Adjust to change				
5. React to emergencies				
6. Make their needs known				
7. Use discretion and common sense				
9. Display self confidence				
10. Display emotional stability				

Is applicant ever:

	Always	Sometimes	Never
1. Verbally abusive			
2. Physically abusive to:			
A) self			
B) others			
3. Physically aggressive			

Additional Comments

Please express below any additional comments regarding the applicant, specifying his/her reason for applying to our residential program:

Signature of Person completing form: _____

Phone # (if different from family)**:** _____

Best day/time to contact: _____

Have you attached?

Copy of Medicaid card_____*
Copy of Birth certificate____*
Copy of picture ID_____*
Copy of SS card_____*
Current physical _____*
Current Psychological report _____*
Current Psychosocial report _____*
Current ISP (if applicable) _____
Copy of Notice of Decision _____

Please note applications cannot be processed if we do not receive this information.

Forms/admissions rev. 10/05