



Gateways Industries
Day Program Admission Application

Admission Information

Place of Admission: Galleria Rayen Village
Requested Attendance M T W Th F
Non-Medical Transportation requested: Yes No *Only able to provide NMT on full 5 day schedule
Is this individual receiving waiver services? Yes No

If 'yes' which waiver (IO, Level 1 etc.) ? _____

County of Waiver/Residence? _____

Acuity Level: A B C

What service are they requesting to receive at the day program? Day Habilitation Vocational Habilitation

Vocational Habilitation Only- Approved to work under Sub Minimum Wage certification through WIOA/DOL?

Yes No

Do they have any add ons in their plan: Behavioral Medical

Demographic Information

Applicant Name: Last: _____ First: _____ Middle: _____

Address: _____ City: _____ Zip: _____

Telephone: _____ County: _____

Birth Date: _____ Birth Place: _____

Sex: Male Female

Contact Information:

SSA Name: _____ Phone: _____

Email: _____

Residential Provider Name: _____

Provider Contact Person/Title: _____ Phone: _____

Email: _____

Guardian Information: Applicant is their own guardian Yes No

If no, please provide the following guardian information:

Name: Last: _____ First: _____ Middle: _____

Address: _____ City: _____ Zip: _____

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

Fax: _____ Email: _____

Relationship to Applicant: _____

Medical Information

Current Height _____ Weight _____ Ambulatory: Yes No

Food allergies _____

Medication allergies _____

Non-food allergies _____

List any **major injuries, illnesses surgeries and/or hospitalizations** – include date(s):

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

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

Will they take any medications during day program hours? Yes No Please list:

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

Personal Care or Toileting Needs while at the Day Program: _____

List any adaptive/assistive equipment _____

Medical needs that require nursing care _____

Is applicant current on immunizations? Yes No

Mental Health Information:

MR Diagnosis: Mild Moderate Severe Profound

MH Diagnosis: Please list any/all: _____

Behavior/Emotional: -

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

Describe hobbies, special interests, favorite activities _____

Does this person have current Behavior Plan or Behavioral Strategies? Yes No

Safety/Supervision:

Supervision required in day program:

Independent visual auditory one on one Other: _____

Toileting

Independent visual auditory one on one Other: _____

Eating

Independent visual auditory one on one Other: _____

In the Community

Independent visual auditory one on one Other: _____

Is this individual an elopement risk? Yes No If yes, provide details _____

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

Background Information:

Previous Day Program/Employment/School:

Dates attended: _____ - _____

Name: _____

Contact Person: _____

City/State: _____ Phone: _____

Reason for leaving: _____

Previous Day Program/Employment/School:

Dates attended: _____ - _____

Name: _____

Contact Person: _____

City/State: _____ Phone: _____

Reason for leaving: _____

Previous Day Program/Employment/School:

Dates attended: _____ - _____

Name: _____

Contact Person: _____

City/State: _____ Phone: _____

Reason for leaving: _____

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) Copy of current ISP, if applicable
- (2) Last 3 months behavioral concerns documentation if applicable
- (3) Current Physician Orders
- (4) Tuberculosis Test Required please provide record

If accepted a completed EMA will be required annually

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.