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:____

<u>Behavior/Emotional:</u> -

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 ☐

<u>Safety/Supervision:</u>

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

____

<u>Background Information:</u>

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.

Any questions please call Roslyn Greene at 330-727-5173