Exceptional Opportunities, Inc.
Home and Community Based Services
Admission Form

Legal Name____
(first) (middle) (last)
Address____
______________________________ Telphone________________
Applicant's Social Security Number_______________________________
Date of Birth________________ Birthplace_____________________
(hospital) (town)
Marital Status S M D W Sex M F Height________ Weight________
Hair Color___________________ Eye Color___________________
Other Identifying Marks_____________________________________
Religious Preference_______________________________________
Please indicate whether or not it is ok to attend another church Y N
Comments____
County of Residence_________________ Registered Voter Y N

Name of Social Worker or Case Manager___________________________
Address____
Phone Number____

Father's Full Name____
(first) (middle) (last)
Address____
______________________________ Telephone________________
Birthplace_________________________ Occupation______________
Education_________________ Military Service___________________
Workplace_______________________ Work Telephone_____________

Mother's Full Name____
(first) (middle) (maiden) (last)
Address____
______________________________ Telephone________________
Birthplace_________________________ Occupation______________
Education_________________ Military Service___________________
Workplace_______________________ Work Telephone_____________
Parents Marital Status________________ Relgion__________________
Date of Marriage___________________ Place_____________________

Legal Status of Applicant____
Legal Guardian_____________________________ Telephone__________________
Address____
Guardianship number____________________ Court___________ Date___________
Representative Payee for Finances____
Address____
____ Telephone__________________
Other____

Other Children in Family
1) Name___________________________________Birthdate___________________
Address____
2) Name___________________________________Birthdate__________________
Address____
3) Name_________________________________Birhtdate___________________
Address____
Others in household ____
____

Language Spoken/Understood____

Emergency Contact Person (other than parent/guardian)___________________________
Address____
Telephone___________________________ Relationship_______________________

Source of Referral____
____

Are you currently:			
	Occupying substandard housing	Y	N
	Involuntarily displaced	Y	N
	Paying more than 50% of income for rent	Y	N

Additional Comments____
____
____
____

Does applicant have history of substance abuse?	Y	N
Does applicant have history of mental illness?	Y	N

Comments____
____

Does applicant have any allergies to food, medication, other? Y N (please list)

__________________________________Type of rection______________________

__________________________________Type of reaction______________________

__________________________________Type of reaction______________________

__________________________________Type of reaction______________________

__________________________________Type of reaction______________________

Is the applicant on a special diet ordered by the physician? Y N

Type of Diet_________________________ Date started______________________

Reason for diet____

*(must have written statement from physician if special diet is needed)

List all activities or limitations the applicant is restricted from as ordered by physician.

____

____

*(must have written statement from physician if any limitations)

Does the applicant have any physical disabilities that require the use of special devices?

(wheelchair, braces, walker, orthopedic shoes, splints, etc)________________________________

____

List Preference of Provider:

Physician________________________________ Date Last Exam___________________

Address/Phone____

Hospital____

Address/Phone____

Dentist_________________________________ Date Last Exam___________________

Address/Phone____

Does applicant have dentures? Y N

Optometrist_____________________________ Date Last Exam___________________

Address/Phone____

Does applicant wear glasses? Y N

Pharmacy____

Address/Phone____

Mortician____

Address/Phone____

Does applicant have a burial fund? Y N If yes, provide copy.

Current Medications (prescribed & over-the-counter)

Name	Dose	Frequency	Reason for Medication

Past Medications

____
____
____
____
____

Medical History

List all operations, injuries, illnesses which required hospitalization.

Date	Reason	Name/Address Hospital

Illnesses (list year)

______Chicken Pox ______German Measles ______Pneumonia
______Measles ______Polio ______Croup
______Mumps ______Whooping Cough ______Tuberculosis
______Scarlet Fever ______Rheumatic Fever ______Hepatitis A or B

Other____
____
____

Is applicant prone to any of the following? (please check all that apply)

______Asthma ______Strep Throat ______Colds
______Constipation ______Diarrhea ______Weight Gain
______Nose Bleeds ______Vaginal Infections ______Urinary Tract Infect.

Does applicant have seizures? Y N

Age of onset____________________ Type of Seizure____________________________

Date of Last Seizure________________ Frequency______________________________

Immunizations (list date)
DPT/TD Series____
Polio Series____
Measles (Rubeola)____
German Measles (Rubella)__________________________________
Mumps____
Date of Last Mantoux______________ Results____________________
Has applicant ever had a positive Mantoux? Y N
Date of Last Chest X-ray___________________________________
Date of last Tetanus shot__________________________________
Flu shot_____________________ Pnuemovax___________________

Other
Age menstruation began_____________ Date of last period____________
Does applicant have regular menstrual cycles? Y N
If no, please comment______________________________________
Has applicant ever used birth control? Y N
Method____
Date started______________ Date if Discontinued________________

Educational History

Name/Address of Schools Attended	Grade Level	Dates Attended	Year Graduated

Name/Address of Programs Attended	Dates Attended	Comments

Vocational History
Has applicant ever been employed? ______Sheltered ______Competetive
Current Employer or Day Program______________________________
Address/Phone____
____
Dates Attended____
Job Responsibilities_______________________________________
____
____

Past Employers or Day Programs____
Address/Phone____

____

Dates Attended____
Job Responsibilities____

____

Reason for Leaving____

Describe Previous Living Arrangements____________________________________

____

____

____

Describe Previous/Current Services Received_______________________________

____

____

____

Please include any other pertinent information that might allow the applicant to be better served____

____

____

____

____
Signature of Person Completing Application

____
Relation to Applicant

____
Date Completed

Forms to be completed:

Initial Assessment completed	Y	N	Date____________
Psychological Evaluation	y	N	Date____________
Functional Assessment	Y	N	Date____________
Narrative Summary	y	N	Date____________
My Life Assessment	Y	N	Date____________
Consumer Interest Inventory	Y	N	Date____________
Sources of Income	Y	N	Date____________