



## PRELIMINARY APPLICATION FOR ADMISSION

<b>APPLICANT NAME:</b>	<b>SEX:</b> M    F	<b>AGE:</b>
<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b>	<b>SSN:</b>
<b>Telephone:</b>		
<b>Name of Parent(s) or Guardian(s):</b>		
<b>Name of Person Completing this Application:</b>		
<b>From what source did you hear about Jacob's Village?</b>		
<b>Does Applicant have a Court Appointed legal guardian?</b> Yes    No (If yes, a copy of the court decree is required)		
<b>Level of Family Involvement:</b> Intensive    Frequent    Occasional    None		
<b>Medical Coverage/Entitlements:</b>		

RESIDENTIAL STATUS
<b>Where does the Applicant currently live?</b> With Family    With Guardian    Other Supported Living (e.g. group home)    Independently (e.g. apartment)
<b>Why are you currently seeking placement?</b>
<b>Desired month/year of admission:</b>
<b>Is this your first attempt to obtain residential placement?</b> Yes    No (If no please explain previous attempts and outcomes)

PREVIOUS RESIDENTIAL PLACEMENTS (attach additional sheet if needed)		
	1	2
<b>WHERE:</b>		
<b>WHEN:</b>		
<b>REASON FOR LEAVING:</b>		

PRELIMINARY MEDICAL INFORMATION					
<b>Diagnosis of Applicant Disability:</b>					
<b>Current Medications:</b>					
<b>Allergies:</b>					
<b>Special Nutritional Concerns:</b>			<b>Height:</b>	<b>Weight:</b>	
<b>Special Dietary Needs:</b>			<b>Diabetes:</b>	Yes	No
<b>Immunizations Current:</b> Yes            No					
<b>Vision:</b>	OK	Glasses	Partially Sighted	Blind	<b>Describe:</b>
<b>Hearing:</b>	OK	Hearing Impaired	Amplification	Deaf	<b>Describe:</b>
<b>Chronic Medical Problems:</b>					
<b>Surgeries / Hospitalizations and Dates:</b>					
<b>Ambulatory:</b> Yes        No    Assistive Devices (List type of devices:)					
<b>Seizures:</b> Yes        No    (If yes, state type of seizures:)					

**Has the Applicant been evaluated in any of the following areas? (If yes, please note the date of the most recent evaluation and the evaluator, if known):**

Type of Evaluation	Yes	No	Date of Evaluation	Evaluator or Physician
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Audiological				
Visual				
Dental				
Psychological				
Other type (please list):				

SELF-CARE ABILITY: (Circle One)				OTHER COMMENTS (e.g. Note any special equipment needed)	
Bathing	Assistance Needed	Reminders Needed	Independent		
Dressing	Assistance Needed	Reminders Needed	Independent		
Toileting	Assistance Needed	Reminders Needed	Independent		
Feeding	Assistance Needed	Reminders Needed	Independent		
Cognitive Skills	Good	Fair	Poor		IQ:
Physical Coordination	Good	Fair	Poor		
Ability to Understand and Follow Instructions	Understands Everything	Understands Most Things	Has Some Difficulty Understanding Others		
Speech/Communication Skills	Good	Fair	Poor		
Ability to Develop Relationships	Good	Fair	Poor		

SOCIAL & BEHAVIORAL INFORMATION
Leisure Activities Enjoyed:
Behavior Problems and Severity:
Primary Means of Communication:

STATE IN YOUR OWN WORDS THE NATURE OF THE APPLICANT'S ABILITIES AND DISABILITIES

**INCOME / FINANCIAL RESPONSIBILITY**

Personal income received by Applicant from:

Social Security Benefits \$ \_\_\_\_\_ SSI Benefits \$ \_\_\_\_\_

Trust Fund \$ \_\_\_\_\_ Other (give source) \$ \_\_\_\_\_

Approximate Family Income: (Check one)

- Below \$20,000
- \$20,000 - \$39,999
- \$40,000 - \$59,999
- \$60,000 - \$79,000
- \$80,000 & Over

Financial responsibility for residential fees (\$2,000/month) will be assumed by:

Name: \_\_\_\_\_

Relation to Applicant: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_

Comments:

**INSURANCE INFORMATION**

Medicare Number: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ State in which Medicaid is received: \_\_\_\_\_

Health/Accident Insurance: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Life Insurance: \_\_\_\_\_

Burial Insurance: \_\_\_\_\_

Please identify which insurance is primary: \_\_\_\_\_

<b>PARENT / GUARDIAN INFORMATION</b>		
	<b>Father (or male guardian)</b>	<b>Mother (or female guardian)</b>
<b>Name</b>		
<b>Date of Birth</b>		
<b>Address</b>		
<b>City, State, &amp; Zip Code</b>		
<b>Phone</b>		
<b>Occupation</b>		
<b>E-mail</b>		
<b>Employed by</b>		
<b>Business Address</b>		
<b>City, State, &amp; Zip Code</b>		
<b>Business Phone</b>		
<b>Date of Court Decree (if guardian)</b>		
<b>Marital Status of Parents:</b>		

I understand this is a preliminary application only and completion of this form does not create any obligation or duty for Jacob's Village, Inc. to provide a home or residential services to the Applicant.

**Signature of Person Completing Application:** \_\_\_\_\_

**Date:** \_\_\_\_\_