CREST SERVICES

CREST SERVICES
RESIDENTIAL APPLICATION FORM
(This will also serve as a Social History)

List Services in which admission is desired in order of preference:

_____
_____
_____

Applicant's name:_____ SSN_____

Current Address:_____
_____

Telephone Number: _____ Ambulatory? ( ) Y ( ) N
Name and Number of Emergency Contact: _____

Date Admission Desired: _____ Voluntary Admission? ( ) Y ( ) N
Preferred DSP: ( ) Male ( ) Female ( ) No Preference
Preferred Roommates: ( ) Male ( ) Female ( ) No Preference

Date of Birth: _____ Place of Birth _____Sex: ( ) M ( ) F
Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____
Marital Status: _____ U.S. Citizen? _____
Cultural/Ethnic Background: _____
Language(s) Spoken or Understood: _____
_____

Church Affiliation: _____ Attend Church Regularly? _____

Primary Diagnosis: _____
Other Diagnosis: _____
Identifying Marks: _____

Has the applicant ever been arrested? ( ) Y ( ) N
If yes, please provide dates, reasons, and outcomes: _____
_____
_____

Has the applicant ever been involved in a civil action? ( ) Y ( ) N
If yes, please provide dates, reasons, and outcomes: _____
_____
_____

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Previous Services:

(Residential: such as State-Hospital, Schools, Nursing Homes, Private Residential Schools, Foster Homes, Group Homes, etc.)

Services	Address	Dates

Family and Financial Information

Father

Name: _____ SSN: _____
Address: _____ Birthdate: _____
_____ Birthplace: _____
Home Phone: _____ Work Phone: _____

Mother

Name: _____ SSN: _____
Address: _____ Birthdate: _____
_____ Birthplace: _____
Home Phone: _____ Work Phone: _____

Siblings

Name: _____ SSN: _____
Address: _____ Birthdate: _____
_____ Birthplace: _____
Home Phone: _____ Work Phone: _____

Name: _____ SSN: _____
Address: _____ Birthdate: _____
_____ Birthplace: _____
Home Phone: _____ Work Phone: _____

Name: _____ SSN: _____
Address: _____ Birthdate: _____
_____ Birthplace: _____
Home Phone: _____ Work Phone: _____

Name: _____ SSN: _____
Address: _____ Birthdate: _____
_____ Birthplace: _____
Home Phone: _____ Work Phone: _____

Names/Numbers of Friends/Relatives who may have contact with applicant:

Name	Number

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Will the applicant visit with family and friends on weekends/holidays? ( ) Y ( ) N
Is there anyone the applicant should not visit? _____

What relationships are important to the applicant? _____
_____

If applicable, who has legal guardianship? _____
If other than parents, please specify: _____
Address Phone
Date of Guardianship: _____
(Please attach a copy of guardianship papers)

If applicable, who has legal conservatorship? _____
If other than parents, please specify: _____
Address Phone
Date of Conservatorship: _____
(Please attach a copy of conservatorship papers)

Does the applicant receive financial assistance? ( ) Y ( ) N

SSI _____ (Amount) SSA _____ (Amount)
Rent Assistance: ( ) Y ( ) N
Food Assistance/EBT: ( ) Y ( ) N
Payee: ( ) Y ( ) N

Parents _____ Other _____

Medicaid Number _____ Medicare Number _____
Health Insurance ( ) Y ( ) N
Company _____ Policy Number _____
Life Insurance ( ) Y ( ) N
Company _____ Policy Number _____
Face Value _____ Cash Value _____

Savings Account ( ) Y ( ) N Where _____
Burial Account ( ) Y ( ) N Where _____
Trust Fund ( ) Y ( ) N Where _____

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Other Agency Involvement: (vocational rehabilitation, private social service agencies, etc.)
Case Manager/IHH _____ Telephone _____

Address _____

Medical Section

1. Physicians

Current Physician: _____ Date of Last Exam: _____
Address: _____

Current Dentist: _____ Date of Last Exam: _____
Address: _____
Does applicant have dentures? ( ) Y ( ) N

Current Ear Doctor: _____ Date of Last Exam: _____
Address: _____
Does applicant wear a hearing aid? ( ) Y ( ) N

Current Eye Doctor: _____ Date of Last Exam: _____
Address: _____
Does applicant wear glasses? ( ) Y ( ) N

Current Neurologist: _____ Date of Last Exam: _____
Address: _____
Comments: _____

Other Specialist: _____ Date of Last Exam: _____
Address: _____
Reason: _____

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2. Medications

Name	Dose	Frequency	Reason	Prescribed By

Will the applicant require supervision taking medication? _____

Any Special Accommodations? (Pudding, crushed, liquid)_____

3. Allergies

Is the applicant allergic to?

Medications: ( ) Y ( ) N

Please List _____ Type of reaction _____

Food: ( ) Y ( ) N

Please List _____ Type of reaction _____

Other? ( ) Y ( ) N

Please List _____ Type of reaction _____

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4. Diet

Is the applicant on a special diet as ordered by a doctor? ( ) Y ( ) N
(A Statement from the Physician is required regarding dietary instructions)

Date Started _____
Type of Diet _____
Reason for Diet _____

5. Activity

List all activities or limitations from which the applicant is restricted as instructed by a doctor:

_____
_____
_____

Does applicant have any physical disabilities that require the use of special devices? (Wheelchair, Shower chair, Hoyer, Slide board, Gait belt, braces, walker, orthopedic shoes, splints, canes, etc.) If so, please list:

_____
_____
_____

6. Hospitalizations

List all operations/injuries/illnesses the applicant has suffered which required hospitalization:

Date Nature of Hospitalization Name/Address of Hospital

_____
_____
_____

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7. Illnesses/Diseases (List Year)

Chicken Pox	_____	Rheumatic Fever	_____
Measles	_____	Diabetes	_____
Mumps	_____	Cancer	_____
Scarlet Fever	_____	Pneumonia	_____
Cardiac Problems	_____	Croup	_____
German Measles	_____	Tuberculosis	_____
Polio	_____	Hepatitis A	_____
Whooping Cough	_____	Hepatitis B	_____

Other:_____
_____
_____
_____
_____

Is applicant prone to any of the following? (Please check if yes)

Asthma	_____	Strep Throat	_____
Colds	_____	Urinary Tract Infection	
Constipation	_____	(Bladder)	_____
Diarrhea	_____	Vaginal Infection	_____
Nose Bleeds	_____	Weight Gain	_____

Does applicant have seizures? ( ) Y ( ) N
Age of Seizure onset: _____
Date of Last Seizure: _____ Type of Seizure: _____
Frequency of Seizures: Number/Monthly _____ Yearly _____

Does the applicant have any hearing or vision problems that are uncorrected or uncorrectable?_____

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8. Immunizations

Type of Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Booster	Booster
DPT/TD Series							
Polio Series							
Measles							
German Measles							
Mumps							

Date of applicant's last Tuberculin Test (TB): _____
Result: _____
Has applicant ever had a positive TB Test? ( ) Y ( ) N
Date of applicant's last chest x-ray: _____
Date of last Tetanus shot: _____

9. Other

Has applicant ever used birth control? ( ) Y ( ) N
Method: _____
Start Date: _____ Stop Date (if applicable): _____
Has applicant had a Vasectomy or Hysterectomy? ( ) Y Date: _____ ( ) N

For female applicants only:
Does applicant have a regular menstrual cycle? ( ) Y ( ) N
If no please specify: _____
Age menstruation began: _____Date of last period: _____

10. Preferences

Hospital: _____
Address: _____Telephone: _____

Pharmacy: _____
Address: _____Telephone: _____

Mortician: _____
Address: _____Telephone: _____

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11. Substance Abuse History

Please describe the substance abused and list any treatment received: _____

_____

_____

12. History of Interfering Behaviors: ( ) Y ( ) N

If yes please identify Interfering Behaviors: _____

_____

If yes does the applicant have a Behavior Support Plan? ( ) Y Date: ( ) N

If yes has the applicant been referred to I-PART or I-Tabs? ( ) Y Date: ( ) N

If yes is the applicant currently seeing a Psychiatrist? ( ) Y Provider? ( ) N

If yes if the applicant currently seeing a Therapist? ( ) Y Provider? ( ) N

Educational / Vocational / Social Section

1. Educational History

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

Name & Address of Program	Dates Attended	Comments

2. Work History

Has applicant ever been employed? ( ) Day Program/Habilitation ( ) Competitive ( ) Volunteer

Current Agency or Employer:

Agency: _____ From: _____ To: _____

Address: _____

_____

Responsibilities: _____

_____

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3. Skills Checklist

Please mark: 1=consistently; 2=sometimes; 3=never; C= Comments

	1	2	3	Comments
*** Eating ***				
Needs to be fed				
Throws/Plays with food				
Eats with fingers				
Uses cup or glass				
Eats with spoon				
Eats with fork				
Uses knife to spread				
Uses knife to cut				
Eats slowly				
Eats rapidly				
Fussy eater				
Enjoys eating				
Good table manners				
100% independent				
*** Dressing ***				
Needs 100% help				
Resists dressing				
Assists in dressing				
Tries to dress self				
Does most of it alone				
Buttons clothes				
Ties shoes				
Chooses own clothing				
100% independent				
*** Hygiene ***				
Needs complete help				
Washes hands				
Washes face				
Brushes teeth				
Combs or brushes hair				
Bathes w/supervision				
Bathes w/no help				
Shaves				
Shampoos Hair				
Complete independence				
*** Bathroom ***				
Briefs				
Scheduled bathroom time				
Can indicate need				
Soils during the day				
Soils during the night				
Cares for self at toilet				
Cares for self during Menstrual cycle				

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4. Interfering Behavior Information

Please mark: 1=consistently; 2=sometimes; 3=never; Comments-Please explain if you mark an area a 1 or 2.

	1	2	3	Comments
Hyperactive				
Aggressive				
Withdrawn				
Depressed				
Uses tobacco				
Uses alcohol (explain)				
Other drugs (explain)				
Uses self stimulation, (Rocking back and forth etc.)				
Destruction of property				
Uses abusive language				
Physically abuses others				
Leaves without permission				
Teases others				
Elopes/Runs away				
Refuses to go to work/day program/volunteer opportunity				
Steals others' things				
Lies/cheats				
Hoards things				
Tears/removes clothes or other items				
Eccentric habits				
Becomes upset if redirected				
Requires 1:1 support				
States they are ill when they are not or without S/S				
Changes mood often				
Easily Cries				
Harmfully inflicts self				
Sexual Interfering Behavior				

Additional Comments: _____

_____

_____

_____

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Hobbies, leisure time activities, interests – please list: _____

_____

_____

5. Current Goals and Supports:

Residential: (Cooking, Housekeeping, Clothing Care, etc.)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Vocational:

1. _____ 3. _____
2. _____ 4. _____

Parents, guardians, or significant others-please list goals you feel are appropriate for the applicant

_____

_____

_____

_____

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Data Collection Notification

The information we have asked you to provide is necessary for the effective administration of the services for which you are receiving. The information collected will only be used by authorized agency personnel. Use of this information for purposes other than explained herein will not be made without your prior written approval, unless law specifically authorizes other use. You also have the right to review any information that is maintained by this agency about you.

Applicant's Signature	Date
Parent/Guardian's Signature	Date
Case Manager's Signature	Date

Required Material

Attach any other material specifically requested by the residential facility such as:

1. Most recent psychological report on file
2. Most recent education and/or vocational report on file
3. Information on social adjustment
4. All necessary information permits/releases
5. Physical examination (as required by agency)
6. Other medical specialty reports
7. Other reports on file

At the time of placement, information may need to be updated and current within a year before time of admission.