

Aldrich Care Solutions, LLC.

Application for Admission

Please complete the application in full. If you are submitting an attachment, please indicate the attachment name and page number where information to the questions below can be found. If a question does not apply, please indicate N/A.

SIS INFORMATION	
LEVEL	
TIER	
DATE	

Please select service(s) for referral:

- Respite Care
- In-home supports
- Private duty nursing

Has the applicant previously applied for services?

If yes, when?

Date: _____

Personal/Health Information:

Name: _____ Gender: _____ Age: _____ Date of Birth: _____

Address: _____ Phone Number: _____
(Street) (City, State) (Zip)

Social Security #: _____ U.S. Citizen: Yes No

Legal Status (own guardian?): Yes No (If yes, has a capacity evaluation been completed?)

Date completed: _____

Primary Language: _____

Parent(s):

Name: _____

Address: _____
(Street) (City, State) (Zip)

Home #: _____ Cell #: _____

Email Address: _____

Name: _____

Address: _____
(Street) (City, State) (Zip)

Home #: _____ Cell #: _____

Email Address: _____

Sibling(s)/Significant Others:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____
(Street) (City, State) (Zip)

Name: _____ Relationship: _____

Address: _____ Phone Number: _____
(Street) (City, State) (Zip)

Other Contact Information:

Legal Guardian/Authorized Representative: _____

Relationship: _____

Address: _____
(Street) (City, State) (Zip)

Home #: _____ Cell #: _____

Power of Attorney (Healthcare, Financial): _____

Contact Information: _____

Advance Directive: (if applicable, please attach copy): _____

Support Coordinator: _____ Phone Number: _____

Referring CSB: _____ Fax Number: _____

Address: _____ Email: _____
(Street/Suite) (City, State) (Zip)

Primary Care Physician: _____ Phone Number: _____

Address: _____
(Street/Suite) (City, State) (Zip)

Current Diagnoses: _____

Reason for Services/Application: _____

Please List the Dates Received for the Following Vaccinations: (*The following Vaccines are required for admissions into Amazing Lyf programs. please attach medical record as applicable)

Td/Tdap Tetanus, Diphtheria, Pertussis (Recommended every 10 Years)	Pneumococcal	MMR Measles, Mumps, Rubella	HPV for Women (for women entering 6th grade after 2008/may not apply)	Chickenpox	Hepatitis B

Consulting Physicians: (Cardiologist, Psychiatrist, Dermatologist, Neurologist, Dentist, Etc.)

Name	Specialty	Phone Number

History of Applicant (including current status):

	Dates	Hospital/Institution	Attending Physician	Type of Treatment
Previous				

Incarceration				
Mental Illness/ Psychiatric treatment				
Alcohol or Drug Abuse				
Infectious Diseases (MRSA, HIV, Hepatitis, TB, etc.)				
Other Hospitalizations				

Medications: List all medications currently being taken (use additional pages as necessary).

Medication	Dosage	Frequency	Indication	Medication	Dosage	Frequency	Indication

Previously Taken Medications (Does not apply to collaborations — attach copy if necessary)

Medication	Dosage	Frequency	Indication	Medication	Dosage	Frequency	Indication

Present Conditions:

Ambulation

Independent

Impairments

Vision

Special Precautions

Aggression

Individual Has:

Dentures

- Wheelchair
- Cane/Walker
- Unsteady Gait
- Hearing
- Speech
- Bowel/Bladder
- Chokes easily
- Hides Medications
- Wanders
- Elopes
- Eyeglasses
- Hearing Aid
- Braces/Splints
- Other_____

List and Purpose of Any Adaptive Equipment Not Otherwise Specified: _____

History of Illnesses/Injuries: _____

Date of Last Psychological Evaluation (please attach a copy): _____

Additional Comments Related to Medical/Healthcare: _____

Drug Contraindications/Allergies: _____

Food Allergies: _____

Self-Care Capabilities:

Self-care Capability	Independent	Verbal Prompt	Physical Prompt	Total Assistance
Washing face and hands				
Bathing				
Hair Care				
Nail Care				

Shaving				
Brushing teeth and/or dentures				
Toileting				
Dressing/Undressing				
Feeding Abilities				
Use of Public Transportation				
Self-Medication				
Food Preparation				

Communication:

- Verbal
 Vocalizations
 Gestures
 Signs
 Communication Device(s):

Describe how individual interacts with others: _____

Describe the best way to interact with the individual: _____

Likes, Dislikes or Preferences of the Individual: _____

Is Individual Involved in Any Regular Community Activities: _____

Behavior Supports:

Does Individual currently/previously have a Behavior Supports Plan? Yes No

Name of Consultant: _____ Company: _____

Phone Number: _____

Current Placement:

Family Home Residential Group Home: _____

Other: _____

Group/Other home contact info: _____

Day Support: _____

School: _____

Other: _____

Financial Information:

Waiver:

DD Waiver

Other Funding Source (please specify): _____

Income:

Source

Amount

SSA _____

SSI _____

SSDI _____

Wages _____

Other _____

Medical Insurance:

Medicaid # _____

Medicare # _____

Other _____

Policy #: _____

Signature: _____ Date: _____

Title: _____

For Office Use

Application Received: _____ Application Accepted Rejected Waiting List
(DATE)

Date Letter Sent _____ Admission Date: _____