

APPLICATION FOR ADMISSION

**Scott Key Center, Inc.
1050 Rocky Springs Road
Frederick, Maryland 21702
Office (301) 600-1600 FAX (301) 600-6016**

I. Applicant/Family/Contact Information

Name of Applicant: _____ Date of Birth: _____
 First Middle Last

Home Address: _____ Home Phone: _____

County of Residence: _____ Length of County Residency: _____

Social Security Number: _____ Medical Assistance Number: _____

Medicare No.: _____ Other Ins. No.: _____ Company: _____

Receive S.S.I. Benefits? Yes/No If not, any other income (death benefit, Social Security, Pension etc.)? _____
(circle one)

Client's Monthly Income? _____

Father's Name: _____ D.O.B. _____ Mother's Name: _____

Place of Occupation: _____ Education: _____

Place of Business: _____ Business Phone: _____

Mother's Occupation: _____ Education: _____

Place of Business: _____ Business Phone: _____

If applicant does not live with parent(s), who is the person responsible? _____

Brothers/Sisters (check before name if living at home):

<u>Name(s):</u>	<u>D.O.B.</u>	<u>Occupation:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Others Living In Home:

<u>Name(s):</u>	<u>Relationship to Applicant:</u>
_____	_____
_____	_____
_____	_____

II. Applicant's Background Medical Information

Mental/Physical handicaps (please provide medical diagnosis, if known):

Primary: _____

Secondary: _____

(please continue on to page 2.)

Date of Applicant's last physical evaluation: _____ Physician _____

Address: _____ Office Phone: _____

Date of last Psychological evaluation: _____ Psychologist: _____

Family Physician or Clinic: _____

Address: _____ Office Phone: _____

Other Specialists or Special Clinics: Yes/No If yes, who and where: _____

(circle one)

_____ Purpose: _____

Results/Recommendations: _____

Hospitalized: _____ Name of Hospital: _____

Address: _____

Other Hospital: _____

Address: _____

Results/Recommendations: _____

Does Applicant currently experience or is applicant candidate for seizures?: _____ Type:?

Age at onset: _____ When/where last?: _____ Frequency: _____

Medications/dosage(s) used?: _____

III. Applicant's Emergency Contact Information

Who should be contacted in case of an emergency other than responsible person listed on page 1? (friend, neighbor, other relative, etc.)

1. Name: _____ Relationship: _____

Address: _____ Phone: _____

2. Name: _____ Relationship: _____

Address: _____ Phone: _____

IV. Applicant's General Assistance Needs

Is applicant "ambulatory"? Yes/No If not, how much assistance is needed? Uses cane?: Yes/No

(circle one)

(circle one)

Has braces? Yes/No Needs leading?: Yes/No Requires help of another person?: Yes/No

(circle one)

(circle one)

(circle one)

(please continue on to page 3.)

IV. Applicant's General Assistance Needs (continued from page 2.)

If so, in what manner? _____ Needs help only to raise of sit?: Yes/No
(circle one)

Is applicant partially confined to a wheelchair?: Yes/No Is applicant totally confined to a wheelchair?: Yes/No
(circle one) (circle one)

Is applicant totally dependent? Yes/No Is applicant toilet-trained for urinating?: Yes/No For bowels?: Yes/No
(circle one) (circle one) (circle one)

Makes needs known?: Yes/No Verbally?: Yes/No What word(s)?: _____
(circle one) (circle one)

Does applicant "gesture"?: Yes/No If yes, what gesture(s)?: _____
(circle one)

Does applicant dress self?: Yes/No Undress self?: Yes/No What help is needed?: _____
(circle one) (circle one)

Does applicant feed self?: Yes/No Use spoon?: Yes/No Use fork?: Yes/No Use knife?: Yes/No
(circle one) (circle one) (circle one) (circle one)

Drink from a glass? Yes/No Cup?: Yes/No Allergies (food, drug, pollen, etc.)? _____
(circle one) (circle one)

Restrictions (physical, recreational, work)? _____

Speech: No speech: _____ Single words: _____ Sentences: _____

Understanding: _____

Does applicant use words or expressions (such as "pee" for urine) that may not be understood?: _____

If yes, please describe: _____

Hearing: Normal?: _____ Impaired? _____ Hearing aide used? _____

Vision: Normal?: _____ Impaired?: _____ Glasses worn?: Yes/No
(circle one)

V. Applicant's General Personality/Character Traits

Particular mannerisms or habits to be noted: _____

Is applicant shy?: Yes/No Openly friendly?: Yes/No Any behavior problems?: _____
(circle one) (circle one)

If yes, please describe: _____

Does applicant have any particular fears of animals, height, elevators, escalators, sirens, vehicles, people, etc.?:

If yes, please describe to what? _____

Describe applicant's reaction(s): _____

In general, how does applicant react to anxiety or a stressful situation? Does he/she cry, withdraw, throw tantrums, etc.?:

Please describe: _____

Does applicant relate well to others?: Yes/No Does he/she seek friendships or is he/she a loner?: _____
(circle one)

Describe any alliances or frictions in family or residence to be noted by SKC: _____

Is applicant abusive to others?: Yes/No To self?: Yes/No
(circle one) (circle one)

(please continue on to page 4.)

V. Applicant's General Personality/Character Traits (continued from page 3.)

How does applicant relate to adults in authority? _____

Has applicant had experience of being cared for by adults other than family members? Yes/No If yes, please describe:
(circle one)

Accustomed mode/method of reassurance/ reward for doing a good job? (high five, "good job", etc.):

VI. Applicant's Medicinal Needs

Is applicant on any medication(s)?: Yes/No
(circle one)

<u>Prescribed medication</u>	<u>Reason</u>
_____	_____
_____	_____
_____	_____
_____	_____

VII. Applicant's General Activities/Interests/Community Involvement

Schools/Programs/Work, etc.

<u>Name:</u>	<u>Type</u>	<u>Dates</u>	<u>Reason for leaving</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Was applicant's attendance regular and punctual?: Yes/No Comments: _____
(circle one)

Institutional/Residential Admissions:

Name and Address:	Type	Date entered	Date Left
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VIII. Applicant's General Physical Information

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: _____

COLOR OF EYES: _____ COLOR OF HAIR: _____ LANGUAGE: _____

IDENTIFICATION MARKS: _____

Signature: _____ Date: _____

Witness: _____

=====

FOR OFFICE USE ONLY

Date of Admission: _____ Program: _____

Reason for Non-Admission: _____

Date of Withdrawal/Transfer: _____ Reason: _____

COMMENT(S): _____

Signature: _____

Position: _____