ADMISSION INFORMATION CHECKLIST

APPLICANT:_____

Below is a listing of information needed before scheduling the Pre-Admission Interdisciplinary meeting.

NEED:

_____ 1. Release of Information

_____ 2. Fully Completed Application

_____ 3. Neuro Psychological/Psychological

_____ 4. Social History

_____ 5. Medical Information

___ a. Physical Examination
___ b. Medication History
___ c. Hepatitis B Verification
___ d. Dental Records
___ e. Nutritional Status

_____ 6. Therapy

___ a. Speech/Language Pathology
___ b. Occupational Therapy
___ c. Physical Therapy

_____ 7. Educational/Vocational Information

___ a. IEP, IPP or IHP
___ b. Vocational

_____ 8. Financial Information

___ a. Medical Assistance
___ b. SSI
___ c. SSDI
___ d. TBI Waiver Eligibility

_____ 9. Any other pertinent information that would assist in meeting the applicant's needs.

APPLICATION FOR TBI SERVICES

INSTRUCTIONS: Answer as completely as possible. If it does not apply, write NA, if there is none, write none. Do not leave any lines blank.

Date: _____

I. Identifying Information:

Name:_____
(First) (Middle) (Last) (Nickname)

Current Address: _____
(Street) (City) (County) (State) (Zip)

Permanent Address: _____
(Street) (City) (County) (State) (Zip)

Telephone Number _____ Social Security Number _____

Date of Birth _____ Place of Birth _____
(City) (County) (State)

Age _____ Sex _____ Height _____ Weight _____ Color of Hair _____Color of Eyes _____

Marital Status ____Single_____ Dependents _____ Race _____

Citizenship Status _____ Religion ___ _____

Primary Disability _____

Secondary Disabilities _____

Ambulatory: Yes ____ No _____ Identifying Marks _____

Language Spoken or Understood _____ _____

Does applicant have a ND Photo Identification Card: Yes _____ No _____

Person to Contact in Case of an Emergency _____

Address _____
(Street) (City) (County) (State) (Zip)

Telephone Number: (Home) _____ (Work) _____

Other family members related to this applicant: (All brothers and sisters)

First Name Last Name	Relationship	Address	Telephone

II. Referral Source:

Name and addresses of agencies, schools, or institutions referring applicant for services.

Name Agency Address Phone #

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Other Agencies Involved _____

_____

III. Family:

Parents Name _____ Home Phone # _____

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

Mother's Maiden Name _____

Birthdate of Father _____ Birthdate of Mother _____

III. Family Cont.

Birthplace of Father _____

Birthplace of Mother _____

Father's Employer _____ Business Phone_____

Mother's Employer _____ Business Phone _____

Are parents separated _____ Divorced _____

Is father deceased _____ Is mother deceased _____

IV. Guardianship

Has the applicant been adjudicated incompetent _____
If yes, a copy of adjudication papers must be enclosed.

Legal Guardian _____

_____
(Address) (County) (Phone)

Full Guardianship ____ Limited Guardianship ____ Conservatorship ____

If limited, list what areas _____

Where did guardianship action occur? _____

What date did guardianship or conservatorship action occur? _____

Does applicant have an advocate? _____

Is applicant a ward of Grafton Developmental Center? _____

If yes, what date did wardship occur? _____

V. Service Needs

Does applicant have housing available at the present time? _____

If yes, Name: _____ Address: _____

If no, who will make arrangements _____

What type of residential services does the applicant need? _____

What type of Day Programming does the applicant need? _____

VI. Educational History

What schools has applicant attend:	During what years?	Reason for leaving?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle last school grade attended: K 1 2 3 4 5 6 7 8 9 10 11 12

Did the applicant receive Special Education Services or attend Regular Education Classes?

_____

Can the applicant read? Yes_____ No _____ Level _____

Can the applicant write? Yes_____ No _____ Level _____

Can the applicant: tell time Yes _____ No ____ count by ones Yes ____ No _____

count coins Yes _____ No _____

VII. Work History

Has the applicant ever been employed? Yes _____ No _____
If yes, please list employers:

_____
(Name of last employer) (Address) (Dates employed)

_____
(Type of Work) (Reason for Leaving)

_____
(Name of previous employer) (Address) (Dates employed)

_____
(Type of Work) (Reason for Leaving)

What type of work does the applicant desire: _____

VIII. History of Treatment and Training:

List clinics, schools, mental health centers, public and/or private hospitals, adjustment training centers, and other facilities where applicant has received treatment, evaluation, or training.

Dates: From	To	Places and Address	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the applicant ever had a vocational evaluation? Yes _____ No _____ Date _____

Age of onset of disability _____ Describe: _____

_____

_____

_____

Reason for application for services _____

_____

_____

_____

_____

_____

_____

_____

Please list other skills or hobbies: _____

_____

BEHAVIOR INFORMATION

	Check if answer is yes	Comments
Is hyperactive		
Is aggressive		
Is withdrawn		
Is depressed		
Has excessive habits (i.e. smoking)		
Uses disruptive noises		
Engages in self-injurious behaviors		
Others		

IX. Applicant's Financial Information

Applicants Monthly Income: Current Amount

Social Security _____

Supplemental Security (SSI) _____

Aid to Dependent Children (AFDC) _____

Work Income _____

Family _____

Food Stamps _____

Housing Assistance _____

Miscellaneous (circle all that apply) _____
(Insurance, Railroad Retirement, Vet Adm, BIA, G.A., etc)

If applicant is not receiving Social Security or SSI, please explain: _____

_____

Social Security Information:

Date of Application _____ Date of Rejection _____

Date of Appeal _____ Accepted/Rejected Date _____

Applicant Resources: If yes: Account Number and Where Located

	Yes	No	
Trust Account	( )	( )	_____
Checking Account	( )	( )	_____
Savings Account	( )	( )	_____
Burial Account	( )	( )	_____
Certificates of Deposits	( )	( )	_____
Savings Bonds	( )	( )	_____
Life Insurance	( )	( )	_____

Miscellaneous _____

Does applicant have a representative payee for any of the above? Please indicate.

Name of Payee _____

Address _____ Phone _____

Medical Insurance Information:

Covered by Medical Assistance: Yes _____ No _____ County _____

If not, has it been applied for? Yes _____ No _____ MA # _____

If yes, date applied _____ County applied to _____

Date accepted _____

Covered by Medicare? Yes _____ No _____ Medicare # _____

If no, has it been applied for? Yes _____ No _____

If yes, date applied for _____ Date accepted _____

Private Medical Insurance? Yes _____ No _____ If yes, name and address of

company, and policy number _____

_____

Signature of individual completing form: _____

_____
(Title or Relationship to the applicant)

Address _____ Phone _____ Date _____

Applicant's Signature _____ Date _____

MEDICAL SECTION

LIST OF PHYSICIANS

1. Current Doctor _____ Date of last exam _____

   Address _____ Date of last physical _____

   City _____ State _____ Zip _____ Phone Number _____

2. Current Dentist _____ Date of last exam _____

   Address _____ Dentures: Yes ( ) No ( )

   City _____State _____ Zip _____ Phone Number _____

3. Current Ear Doctor _____ Date of last exam _____

   Address _____ Hearing Aid: Yes ( ) No ( )

   City _____ State _____ Zip _____ Phone Number _____

4. Current Eye Doctor _____ Date of last exam _____

   Address _____ Glasses: Yes ( ) No ( )

   City _____ State _____ Zip _____ Phone Number _____

5. Current Neurologist _____ Date of last exam _____

   Address _____ Seizures: Yes ( ) No ( )

   City _____ State _____ Zip _____ Phone Number _____

6. Current Psychiatrist _____ Date of last appt. _____

   Address _____ Date of next appt. _____

   City _____ State _____ Zip _____ Phone Number _____

7. Other Specialists_____ Phone Number _____

   Other Specialists _____ Phone Number _____

CURRENT MEDICATION

NAME	DOSAGE	FREQUENCY	REASON FOR MED

Date of last lab work _____

Laboratory procedure complete _____

Results _____

Does the applicant require assistance with administering medication? Yes _____ No _____

If yes, explain: _____

_____

* A copy of any current medication prescription orders must accompany individual at the time of admission.

ALLERGIES

Is applicant allergic to:

A. Medication?
Yes ( ) No ( ) Please list _____ Type of reaction _____

_____ _____

_____ _____

B. Food?
Yes ( ) No ( ) Please list _____ Type of reaction _____

_____ _____

_____ _____

C. Other?
Yes ( ) No ( ) Please list _____ Type of reaction _____

_____ _____

_____ _____

DIET

Is applicant on a special diet as ordered by a medical doctor? Yes _____ No ___ x ____

Date started _____ Type of diet _____ Reason for diet _____

Doctor's Name _____ Address _____ Phone _____

ACTIVITY

1. List all activities or limitations applicant is restricted from as ordered by a medical doctor:

   _____

   _____

   A copy of doctor's orders must accompany applicant upon admission.

2. Does applicant have any physical limitations that require the use of special devices? (wheelchair, braces,

   Walker, orthopedic shoes, splints, canes, etc.) Please list _____

   _____

Describe use: _____

_____

MEDICAL HISTORY

In addition to the following information, all past medical history information must be enclosed with this document.

1. List all operations/injuries/illnesses the individual suffered which required hospitalization.

Date	Nature of Hospitalization	Name and Address of Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. List past illnesses, month and year: _____

_____

_____

_____

_____

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

Constipation _____ Nose Bleeds _____ Strep Throat _____ Weight Gain _____ Asthma _____

Diarrhea _____ Colds _____ Vaginal Infections _____ Urinary Tract Infections (Bladder) _____

Does the applicant have a seizure disorder? Yes _____ No _____ Age of onset _____

Date of last seizure _____ Type of Seizures _____

Average number of seizures per month _____

Hepatitis B Status: Immune _____ Susceptible _____ Carrier _____ Unknown _____

3. Immunization Records:

Please attach or forward a copy of all immunizations

Last Mantoux _____

Has the applicant ever had a positive TB test? Yes _____ No _____

Last Chest X-ray _____ Last Tetanus shot _____

4. Other

Age menstruation began _____ Date of last menstrual cycle _____
Does the applicant have regular monthly menstrual cycles? Yes _____ No _____
If no, please comment: _____

Has the applicant ever used birth control? Yes _____ No _____ Method _____
Date started _____ Date discontinued if applicable _____

Has the applicant ever been sterilized? Yes _____ No _____ Method _____
Date _____

Signature of individual completing Medical History Form: _____
(Title or Relationship to the Applicant)

Address _____ Phone _____ Date _____

All information given on this application is confidential and is used only by authorized staff to provide the best service possible for the applicant or to apply for services or benefits that the applicant may be entitled to.

Required material to be submitted with the application is:

___ Neuro-psychological report

___ Social History

___ Vocational Evaluation (if requested)

___Other relevant evaluation information

___Current physical examination

___Dental examination

___ Signed prescription for current medications

___ Photo of applicant

If evaluations are not completed at time of application, please list with dates of scheduled appointments.