



Chesapeake Care Resources, Inc.

80 MARYSVILLE ROAD NORTH EAST, MARYLAND 21901-2317 (410) 287-5040 FAX (410) 287-5049

APPLICATION FOR SERVICE

(effective 01/23/09)

Today's Date: _____

(ALL INFORMATION IS CONSIDERED CONFIDENTIAL)

Name: _____ Social Security #: _____

Address: _____

Phone #: (____) _____

Date of Birth: _____ Place of Birth: _____

Referred by (Person or Agency): _____

Person filling out application: _____ / _____

Contact # _____ (Printed) _____ (Signature)

Mother/Guardian's Name: _____

Date of Birth: _____ Social Security #: _____

Father/Guardian's Name: _____

Date of Birth: _____ Social Security #: _____

Siblings:

Name: _____ D.O.B: _____

Address: _____ Phone #: _____

Disability: yes / no: If yes explain: _____

Name: _____ D.O.B: _____

Address: _____ Phone #: _____

Disability: yes / no: If yes explain: _____

Name: _____ D.O.B: _____

Address: _____ Phone #: _____

Disability: yes / no: If yes explain: _____

Service(s) requested:

_____ Day Habilitation _____ Lokey Center _____ Residential _____ Respite

Reason for Referral or Applying to Chesapeake Care Resources, Inc.: _____

- PERSON(S) TO CONTACT IN CASE OF EMERGENCY (parent, friend, etc.):

Name: _____ Relationship: _____
 Address: _____ Home Phone #: _____
 _____ Work #: _____
 _____ Other#: _____

Name: _____ Relationship: _____
 Address: _____ Home Phone #: _____
 _____ Work #: _____
 _____ Other #: _____

PERSONAL INFORMATION

- Sex (circle): M F Height: _____ Weight: _____ Race: _____
- Color of Hair: _____ Color of Eyes: _____ Marital Status: _____
- Identifying Marks: _____
- Language Spoken or Understood: _____
- Language(s) used at home: _____
- Sign Language: Fluent _____ Understands some _____ No _____

THIS SECTION MUST BE COMPLETED FOR APPLICANTS OVER 18 YEARS OF AGE.

- Are you competent? _____
- Has legal competence been determined? _____
- Has guardianship been established? Yes _____ No _____ (If yes, please provide a copy)
- Type (person/property, medical/dental/treatment, etc.): _____
- Name of Court/Judge: _____ Date of Judgment: _____
 Address: _____ County/State: _____

FINANCIAL INFORMATION Please list all sources/amounts of financial support for the applicant:

- Salary: _____ per _____
- Supplemental Security Income: _____
- Social Security: _____
- Veterans Benefits: _____
- Interest from bank account(s): _____
- Other Income: _____
- **TOTAL MONTHLY INCOME:** _____
- OTHER ASSETS (Balance): _____
- Savings: _____
- Checking: _____
- Burial Fund: _____
- Trust Fund: _____
- Other: _____

MEDICAL INFORMATION

- Diagnoses & when diagnosed: Primary _____
Secondary _____
- Current Medications (*indicate dosage & times*): _____

- How do you take medicine? (*Ex. crushed in applesauce, liquids, whole, via feeding tube*) _____
Independently: _____ Type of Assistance: _____
- Do you require any medications by injection? Yes _____ No _____ If yes, specify: _____
- Do you use oxygen or a CPAP? Yes ___ No _____ If yes, describe: _____
- Do you have problems swallowing? (explain) _____
Have you had a swallow study? _____ When (year)? _____
- Do you have seizures? Yes _____ No _____ Type: _____ How often? _____
Describe: _____
Average duration of seizure: _____ (minutes) Date of last seizure: _____
- Do you have a history of body temperature and/or thyroid problems? _____
- Do you have a history of sleeping problems? Yes _____ No _____ If yes, describe: _____
- List any medication allergies: _____
List other allergies: (*food, environmental, etc.*) _____
- Do you have any prostheses or invasive devices? _____ Specify: _____
- Do you have a history of skin problems? Yes _____ No _____ If yes, describe: _____
- Do you have other medical conditions or problems? _____ Specify: _____
- Have you received Hepatitis B vaccinations inoculations? Yes _____ No _____
Type: _____
Dates: #1 _____ #2 _____ #3 _____
Month/Year Month/Year Month/Year
- Last Hepatitis B testing:
Hep BsAg Date: _____ Results: _____
Hep BsAb Date: _____ Results: _____
- Physician(s), Health Facility providing medical care:
1. Primary Care physician/Group: _____
Address: _____
Phone: _____ Last Seen: _____

• **MEDICAL INFORMATION – Continued**

2. Dental Care is provided by: _____
Address: _____
Phone: _____ Last Seen: _____
3. Neurologist: _____
Address: _____
Phone: _____ Last Seen: _____
4. Orthopedist: _____
Address: _____
Phone: _____ Last Seen: _____
5. Psychiatrist: _____
Address: _____
Phone: _____ Last Seen: _____
6. Other Medical Professionals:
- a. Name: _____ Phone: _____
Address: _____
Specialty: _____ Last Seen: _____
- b. Name: _____ Phone: _____
Address: _____
Specialty: _____ Last Seen: _____

INSURANCE INFORMATION:

Medical Assistance #: _____ Provider: _____
Medicare #: _____
Supplemental Health/Dental Insurance: _____
Life Insurance (Company/Amount): _____

OTHER CONSIDERATIONS:

- Have any burial provisions been made i.e., family plot? _____
Specifics: _____
- Does applicant have a living will? _____
- Has a DNR status been established? _____
(If yes to DNR or Living Will please provide a copy)
- If No, do you want to pursue a DNR order? _____

ADAPTIVE EQUIPMENT/DEVICES:

	Remarks/Additional information
_____ Glasses	_____
_____ Helmet (protective head gear)	_____
_____ Splint – Type: _____	_____
_____ MAFOs/Ankle braces/Leg braces	_____
_____ Other: <i>(please list)</i> _____	_____

Comments: _____

FUNCTIONAL AREAS - Continued

ACTIVITIES OF DAILY LIVING

Do You:

Independently
YES/NO

Type of Assistance you require

- Bathe _____
- Dress _____
- Brush Teeth _____
- Comb Hair _____

ACTIVITIES OF DAILY LIVING

Do You:

Independently
YES/NO

Type of Assistance

- Choose Clothing _____
- Care for Personal Belongings _____

CAPACITY TO LIVE INDEPENDENTLY

Do You:

YES

NO

- Desire to live independently _____
- Interact well with others _____
- Maintain a basic budget _____
- Prepare your own meals _____
- Do your own laundry _____
- Keep your room clean _____
- Do other domestic duties i.e., vacuum, dust, and mop _____
- Additional information: _____

TOILETING GUIDELINES:

- _____ Independent
- _____ Independent sitting on regular toilet (does not need supervision)
- _____ Holds onto rails of regular toilet (does not need supervision)
- _____ Performs self-catheterization

COMMENTS: _____

- _____ Toileting skills (requires assistance)
- _____ Sits with supervision on regular toilet
- _____ Holds onto rails of regular toilet with supervision
- _____ Uses adapted toilet: _____ Supervised _____ Unsupervised
- _____ Equipment Needed:
- _____ Tray
- _____ Seatbelt
- _____ Trunk support
- _____ Continues to wear disposable undergarment during toileting skill development

- _____ Totally Dependent
- _____ Requires disposable undergarment (*please indicate what part of the day*)
- _____ All day (or) _____ Before Lunch _____ After Lunch
- _____ Trips _____ Riding the bus home
- _____ Requires catheterization
- _____ Additional information (*liners, double disposable undergarment, etc.*): _____

FUNCTIONAL AREAS (Toileting Guidelines) – Continued

- Toileting schedule (*please specify frequency and times*): _____

- Behavior that indicates the need to use the toilet: _____

- Most likely time of day for bowel movements: _____
Are bowel movements daily? Yes _____ No _____ if no, how often? _____
Are suppositories or enemas needed? Yes _____ No _____ If yes, how often? _____
- COMMENTS: _____

COMMUNICATION

Do You:

**Independently
YES/NO**

Type of Assistance you require

- Make your needs known _____
- Follow a one step direction _____
- Follow a two step direction _____
- Make casual conversation _____
- Are you hearing impaired? _____

METHOD OF COMMUNICATION – Please check all that apply

- _____ Verbal _____ Signs/Gestures _____ Picture Symbols
- _____ Wears Hearing Aide(s) _____ Augmentative Devices (*see next*)
- _____ Other (*please explain in next section*)

- Do you use a communication system? Yes _____ No _____ If yes describe: _____

COMMUNICATION AND WHAT IT MEANS:

- How do you communicate that you like something? _____

- How do you communicate that you dislike something? _____

- Other important information regarding how you communicate with us: _____

COMMUNICATION TABLE:

In this situation	When you do this:	We think it means this:	We should do this:

FUNCTIONAL AREAS – Continued

BEHAVIORAL CONCERNS/ PROBLEMS:

- Are there now or have there ever been behavioral concerns, if so explain: _____

- Behavior Plan: _____ Yes (Please attach) _____ No
- Do you use switches? Yes _____ No _____ If yes describe: _____

COMPUTER TECHNOLOGY:

- If you have a computer at home, do you use it? _____ Yes _____ No
 If yes, please describe how you use it? (ex: games, email, internet surfing) _____

- Method(s) of activation including splints (*please check all that apply*):

_____ Mouse	_____ Touch Window	_____ Regular Keyboard
_____ Trackball	_____ Intellikeys	_____ Adapted Keyboard
_____ JoyStick	_____ Switch Interface	_____ Other (<i>please list</i>):

- List software programs used: _____

- COMMENTS: _____

MOBILITY
Do You:

Independently
YES/NO

Type of Assistance you require

- Ride in a car _____
- Use regular bus seat _____
- Use wheelchair Only _____
- Special Considerations (*Please Check*)

_____ Harness/Vest	_____ Helmet (Protective headgear)	_____ Wheelchair tray
_____ Other Equipment to go home (<i>Please List</i>): _____		

COMMENTS: _____

Are you able to walk? _____ If yes indicate the following:

- | | | |
|------------------------|---------------------|-------------------------------------|
| _____ Independent: | _____ Forward | _____ Turns |
| _____ 2/1-hand support | _____ Trunk support | _____ Cruise holding onto furniture |
| _____ Uses canes | _____ Uses crutches | |

COMMENTS: _____

FUNCTIONAL AREAS (Mobility) – Continued

Do you use a walker? _____ If yes indicate the type:

_____ Standard front (forward push) _____ Standard rear _____ Gait trainer

COMMENTS: _____

Do you use a wheelchair? _____ If so circle type: Manual / Power (and answer other uses):

_____ Maneuvers independently _____ Maneuvers with verbal prompts/supervision

_____ Assists in maneuvering, needs assistance & type: _____

_____ Not able to assist in maneuvering wheelchair

_____ Accessories (Please check where appropriate) _____ Seatbelt

_____ Headrest _____ Chest Harness _____ Laterals

_____ SubASIS bar _____ Tray _____ Ankle straps

If power chair, please describe: _____

(If you are also able to sit in a regular or adapted chair, please complete the following section.)

Are you able to sit in a chair? _____ Yes _____ No If yes indicate type:

_____ In regular chair: _____ with _____ without seatbelt

_____ In adapted chair: If yes, Supports needed (ex: trunk support, seatbelt, abductor, etc.) _____

If you also use a wheelchair, for what activities do you sit in a regular or adapted chair? _____

COMMENTS: _____

WEIGHTBEARING ACTIVITIES:

Able to weight bear? _____ (if time limit of tolerance, note: _____)

_____ Rise to stand from chair/toilet

_____ Lower from stand to sit on chair/toilet

_____ Pull to stand from floor

_____ Use stander

COMMENTS: _____

EDUCATION: List all schools attended:

Name Address Dates Attended/Grade

Elementary: _____

Secondary: _____

Vocational: _____

Other: _____

Additional education experiences or information: _____

ADULT PROGRAMMING/EMPLOYMENT:

- Have you ever attended an adult day program? _____ If yes, give name, and dates attended: _____

- Have you ever had a vocational assessment? Yes _____ No _____ If yes describe: _____

- Have you ever held a job? Yes _____ No _____ If yes describe: _____

NUTRITION/TUBE FEEDINGS:

Do you receive nourishment by way of a feeding tube? _____ If yes, indicate the type of tube, and the prescription (type of supplement, amount, frequency): _____

(If you receive nourishment via tube feedings and also by mouth, please complete the following section.)

NUTRITION/MEALTIME PROCEDURES: (Physician ordered diet)

SOLID FOOD PREPARATION: Check One: _____ 1 _____ 2 _____ 3
Regular Mechanical Pureed

Check all that apply: _____ NAS _____ NCS _____ LFLC
No Added Salt No Concentrated Sweets Low Fat/Low Cholesterol

LIQUID PREPARATION: (ex: thicket, temperature guidelines, etc.) _____

ITEMS NEEDED FOR MEALTIME:

_____ Straw/Adapted Cup (specify) _____
_____ Adapted Spoon/plate (specify) _____

OTHER _____

FURNITURE REQUIRED at mealtime:

_____ Wheelchair _____ With tray _____ Without tray
_____ Regular Chair _____ Seatbelt required _____ No seatbelt required
_____ Adaptive Chair Type: _____

TYPE OF ASSISTANCE REQUIRED at mealtime:

_____ 1:1 Assistance _____ Prompting _____ Independent/Able to feed self

How long does it take for you to eat/finish a meal (example 30 minutes, 1 hour etc.) _____

GENERAL INFORMATION:

- Food/liquids to avoid: _____
- Meal Precautions: _____

- How does individual indicate he/she is finished eating? _____

Additional Comments: _____

CHESAPEAKE CARE RESOURCES, INC.

RELEASE OF INFORMATION

Dear Applicant:

Please list those doctors, hospitals, agencies, schools, or adult centers who could provide Chesapeake Care Resources, Inc. with pertinent medical, educational, vocational, psychological or other assessment information necessary for our records. *(This does not apply to items requested on the letter at the end of this packet, i.e. physical, etc.)*

Service Provider
Address

Contact Person/Phone
Type of Information

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

Name: _____ Date of Birth: _____

We will transfer the above information to a copy of the attached letter.

Please sign the attached Release of Information Permit to facilitate obtaining the records necessary to determine appropriateness of admission.



Chesapeake Care Resources, Inc.

80 MARYSVILLE ROAD NORTH EAST, MARYLAND 21901-2317 (410) 287-5040 FAX (410) 287-5049

RELEASE OF INFORMATION PERMIT

TO: _____

DATE: _____

Please forward a copy of:

for _____, date of birth _____, SS# _____ to:

Chesapeake Care Resources, Inc.
80 Marysville Road
North East, Maryland 21901
(410) 287-5040

It is with my knowledge and permission that I hereby authorize a copy of the requested information to be released to Chesapeake Care Resources, Inc. I understand that I have the right to revoke this authorization at any time by writing to Chesapeake Care Resources, Inc.

This authorization is valid for the period _____ to _____.

Signature* _____

Witness if mark _____

*Individual signature (or mark) is necessary *unless* individual is under age 18 or has been declared legally incompetent by a court of law.

Thank you for your cooperation.



Chesapeake Care Resources, Inc.

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Dear Parent/Guardian:

In accordance with the admission requirements of our agency, you must include the following documents when submitting the APPLICATION FOR SERVICES:

1. *A physical examination form completed by the Primary Care Physician.
2. A copy of the applicant's immunization records, including TB Test within 1 year or chest X-ray report.
3. A copy of all current Doctor's Orders for any medications and/or treatments prescribed for the individual (# including tube feeding, if applicable).

All assessment information from doctors, hospitals, agencies, schools or centers that have been requested per the release that is signed, must be received before the application will be reviewed by the Admission Committee.

If the Admission Committee determines services may be appropriate, a try-out will be scheduled. After the try-out the Admission Committee will make a final decision.

If accepted, any or all of the following documentation may be required prior to admission. If accepted for residential services these (**) must be original documents.

**Social Security card, **MA & Medicare card, **Birth Certificate,
Benefit Award letter(s), Guardianship Order, Meal Benefit Form.

* -The Physical Examination must be within one year prior to the date you submit the Application for Services and must meet CCR requirements. If accepted for services, depending on the start date, a new annual physical may need to be submitted in order to be current. If you must schedule an appointment for an annual physical, we have forms you may take on the visit. Please call our office and we will be happy to provide the forms.

- If tube feeding is applicable, Doctor's order must include: 1) feeding type, amount/rate, and frequency, 2) whether CCR Nursing staff may change/insert new feeding tube (if necessary), 3) if x-ray for proper placement is necessary should a new feeding tube be inserted. Finally, new tube must be available at the CCR site in case of emergency.

Also note: If applying for respite care, please be aware that a scheduled respite will be canceled if 1) current physician's orders (within 90 days) are not on file, and/or 2) required medications are not received by CCR 1 week prior to the service date.