ADMISSION APPLICATION FORM

REED NEXT DAY AND RESIDENTIAL

Section 1: Please complete.

APPLICANT'S BACKGROUND INFORMATION

First Name: ________________________ MI: ________ Last Name: ______________________________

Address: ____

City: ______________________________ State: _______________ County: _______________________

Date of Birth: ___________________________ Social Security Number: __________________________

Current Living Arrangements:

Home with Parent/Guardian____ Lives Independently____ Residential Program_____

Primary Language Spoken: _____________________________________

Religious Affiliation: ____

Does the applicant practice any traditions or practice of faith? Yes____ No _____

If yes, please explain_________________________________

Section 2: Please complete.

N.J. DIVISION OF DEVELOPMENTAL DISABILITIES INFORMATION

Tier Level: _____________ **Social Security Amount**: __________ **Medicaid Number**:______________

Which budget are you approved for: Community Care Program: _______ Supports Program:_________

Select the services you are interested in receiving from REED Next:

____ Individual supports (Residential) ____ Day Habilitation __Supported Employment

___Prevocational Training ____Community Based Supports

Section 3: Please complete.

INSURANCE INFORMATION

Primary Insurance:

Policy Name: _________________________ Policy Number: _________________________________

Prescription Policy Provider: _______________________ Prescription Number: ________________

Secondary Insurance (if applicable):

Policy Name: _________________________ Policy Number: __________________________________

Prescription Policy Provider: _______________________ Prescription Number: _________________

INSURANCE INFORMATION

Primary Insurance:

Policy Holder Name: ______________________________

Policy Name: ______________ Policy Number: ______________

Prescription Policy Provider: ____________ Prescription Number: ______________

Secondary Insurance (if applicable):

Policy Holder Name: ______________________________

Policy Name: ______________ Policy Number: ______________

Prescription Policy Provider: ____________ Prescription Number: ______________

Section 4: Please complete.

DIAGNOSIS AND PLACEMENT HISTORY

Primary Diagnosis

Secondary Diagnosis, if applicable

Please list all previous and all current programs and placements, starting with the most recent. Attach additional paperwork if necessary.

Organization and Program Name: ______________________________

Address: ______________________________

Contact Person and Position: ______________________________

Contact Phone: ______________________________

Staffing Ratio: ______________________________

Start Date: ______________ End Date: ______________

Reason for Discharge: ______________________________

Organization and Program Name: ______________________________

Address: ______________________________

Contact Person and Position: ______________________________

Contact Phone: ______________________________

Staffing Ratio: ______________________________

Start Date: ______________ End Date: ______________

Reason for Discharge: ______________________________

Section 5: Please complete.

CURRENT PLACEMENT INFORMATION

Please describe any concerns you have with the current services:

Please describe what the applicant (or guardian) likes about their current program:

Please describe what the applicant (or guardian) dislikes about the current program:

Section 6: Please complete.

SUPPORT COORDINATOR INFORMATION

Support Coordinator Name: ____________________ Agency: ____________________

Address: ____

City: ______________ State: ______________ County: ______________

Phone Number: ____________________ Mobile Number: ____________________

Email: ____

Section 7: Please complete.

HOSPITALIZATION HISTORY

Name of Hospital: ____

Reason for Admission: ____

Name of Physician or Contact: ____

Date of Admission: ____________________ Date of Discharge: ____________________

Name of Hospital: ____

Reason for Admission: ____

Name of Physician or Contact: ____

Date of Admission: ____________________ Date of Discharge: ____________________

Section 7: Continued.

HOSPITALIZATION HISTORY

Name of Hospital: ____________________

Reason for Admission: ____________________

Name of Physician or Contact: ____________________

Date of Admission: ____________________ Date of Discharge: ____________________

Name of Hospital: ____________________

Reason for Admission: ____________________

Name of Physician or Contact: ____________________

Date of Admission: ____________________ Date of Discharge: ____________________

Section 8: Please complete.

HEALTHCARE PROVIDER INFORMATION

Primary Care Physician Name: ____________________ Practice Name: ____________________

Address ____________________

City: ____________________ State: ____________________ County: ____________________

Last Exam Date: ____________________

Hospital Affiliation: ____________________

Neurologist Name: ____________________ Practice Name: ____________________

Address ____________________

City: ____________________ State: ____________________ County: ____________________

Last Exam Date: ____________________

Hospital Affiliation: ____________________

Psychiatrist Name: ____________________ Practice Name: ____________________

Address ____________________

City: ____________________ State: ____________________ County: ____________________

Last Exam Date: ____________________

Hospital Affiliation: ____________________

Opthamologist Name:________________________________ Practice Name: ______________________

Address____

City: _______________________ State: ____________ County: ___________________________________

Last Exam Date: ____

Dentist Name:________________________________ Practice Name: ______________________

Address____

City: _______________________ State: ____________ County: ___________________________________

Last Exam Date: ____

Ear, Nose and Throat (ENT) Name:_______________________ Practice Name: ______________________

Address____

City: _______________________ State: ____________ County: ___________________________________

Last Exam Date: ____

Section 9: Please complete.

MEDICAL INFORMATION

Does the applicant have any food allergies? Yes______ No_______

If yes, please list the allergies here:

Does the applicant experience headaches, stomach aches, nausea or get sick easily? Yes____ No____

If yes, please explain frequency and recommended response:

Has the applicant had any past medical procedures and/or surgeries? Yes____ No____

If yes, please describe:

Does the applicant have a history of seizures? Yes____ No____

If yes, please complete the section below.

Age of onset: ____

Type of seizure: ____

Frequency: ____

Typical duration: ____

Date of last seizure: ____

Describe any other information regarding seizure activity: _______________________________

Section 10: Please complete.

HEALTH AND WELLNESS

Nutrition Type of Diet: Modified ____ No Restrictions _____

Please describe any current sleep issue the applicant is experiencing:

Sleep Behavior No Issues ____ Past Issues _____ Current Issues _____

Please describe any current sleep issue the applicant is experiencing:

Has the applicant ever been a victim of neglect or abuse including physical, emotional, or sexual abuse?

If yes, please explain:

Has the applicant ever witnessed abuse or domestic violence?

If yes, please explain:

Section 11: Please check all that apply.

ADAPTIVE TECHNOLOGY AND NEEDS

____Wears reading glasses

____Wears sunglasses

____Wears contact lenses

____Cochlear implant

____Uses a walker

____MAFO

____Wears a hearing aid(s)

____Uses a cane

____Uses crutches

____Uses a wheelchair

____Use augmentative and assistive technology for communication

____Other (please describe)

Section 12: Please complete.

PARENT/GUARDIAN AND FAMILY INFORMATION - GUARDIAN 1

Parent/Guardian Name:

___ Mother
___ Father
___ Other:

First Name:

MI

Last Name:

Address:

State: City: Zip:

Home Phone: Work Phone: Cell Phone:

Email:

Preferred Method of Contact: Home Phone ______ Cell Phone______ Email _______ Text ________
(Check all that apply)

Name of Employer and Address:

Marital Status: Married ____ Separated _____ Divorced ______ Single _____ Widowed ______
*If applicable please provide a copy of guardian documents.

Are you the legal guardian? ____Yes _____ No, please contact:

Contact for all communications: ____Yes _____ No, please contact:

Contact for all progress reports: ____Yes _____ No, please contact:

Contact for emergency closings:

Contacts for accidents and minor injuries:

ADMISSION APPLICATION FORM

Section 12: Please complete.

PARENT/GUARDIAN AND FAMILY INFORMATION - GUARDIAN 2

Parent/Guardian Name:

___ Mother
___ Father
___ Other:

First Name: | MI: | Last Name:

Address:

State: | City: | Zip:

Home Phone: | Work Phone: | Cell Phone:

Email:

Preferred Method of Contact: Home Phone ______ Cell Phone______ Email _______ Text ________
(Check all that apply)

Name of Employer and Address:

Marital Status: Married ____ Separated _____ Divorced ______ Single _____ Widowed ______
*If applicable please provide a copy of guardian documents.

Are you the legal guardian? ____Yes _____ No, please contact:

Contact for all communications: ____Yes _____ No, please contact:

Contact for all progress reports: ____Yes _____ No, please contact:

Contact for emergency closings:

Contacts for accidents and minor injuries:

Are there other individuals living in the same home as the applicant? If yes, please provide the following:

	Individual 1	Individual 2	Individual 3
First and Last Name			
Date of Birth			
Gender			
Relationship to Applicant			

Section 13: Please check all that apply and write in family member it applies to..

FAMILY HISTORY

	Yes	No	If yes, indicate name of family/relationship
ADD/ADHD			
Anxiety Disorders			
Developmental Disability, including ASD			
Behavioral Problems			
Bipolar Disorder			
Criminal Behavior/Incarceration			
Depression			
Homicidal Statements/ Actions			
Learning Difficulties			
Schizophrenia			

Section 14: Please check all that apply to the applicant.

EXPRESSIVE LANGUAGE & COMMUNICATION

____ Gestures/Points
____ Uses simple phrases
____ Uses an augmentative device
____ Uses sentences
____ Uses picture exchanges
____ Reciprocal conversations
____ Uses single words
____ Can request wants and needs verbally
____ Can identify common objects and familiar people

Section 15: Please check all that apply to the applicant.

TOILETING

Please select the level of Independence while using the bathroom:
____Independently initiates/requests to use the bathroom
____Full physical assistance with wiping
____Gestural/verbal assistance with wiping
____Independence with wiping
____Schedule trained and/or prompt dependent
____ Incontinence while awake
____ Incontinence while asleep
____ Wears diapers
____ Has menstrual cycle

Section 16: Please check all that apply to the applicant.

SELF-CARE SKILLS

____ Washes hands independently
____ Showers independently
____ Brushes teeth independently
____ Cuts nails independently
____ Combs/brushes hair independently
____ Manipulates fasteners on clothing
____ Shaves independently

Section 17: Please complete.

PERSONAL SAFETY

Does the applicant like to swim? ____ Yes ____ No

Swimming ability:
____ Independent
____ With support from others while in water
____ Cannot swim

Strangers:
____ Aware of potential dangers
____ Not aware of dangers with strangers

Hazards:
____ Can identify hazardous household materials
____ Can identify cleaning products
____ Can identify poisonous items
____ Can identify sharp objects
____ Awareness of hazardous hot temperatures (i.e., fire, stove, hot water)

Traffic and vehicle safety:
____ Aware
____ Unaware
____ Somewhat aware
____ Can cross street independently

Describe level of awareness/level of independence in the following areas

Money Management:

Medication Administration:

Voting:
Using lock and key system:
Managing Valuable Items:
Employment Goals:
Social Media:

Section 18: Please check all that apply.

BEHAVIOR AND SAFETY CONCERNS

____Aggression towards others
____PICA (ingestion of inedible objects)
____Property destruction/Disruption
____Cruelty to animals
____Disrobes/undresses
____Scripting/Non-contextual speech
____Refusal/Non-compliance
____Perseveration
____Dropping
____Inappropriate sexual behavior
____Inappropriate social behavior
____Suicidal thoughts, ideations, and/or planning)

____ Mouthing (puts objects in mouth)
____ Self-Injurious behavior
____ Fecal manipulation/smearing/touching
____ Repetitive behaviors
____ Scripting/Non-contextual speech
____ Self-Stimulatory behaviors
____ Theft
____ Screaming/loud vocalizations
____ Makes false allegations towards others
____ Verbal aggression (explicit/inappropriate language)
____ Forced emesis (vomiting)
____ Homicidal (thoughts, ideations, and/or planning)
Other:

Explain any behaviors that were checked and provide frequency and intensity:

Section 19: We would like to learn as much as possible about the applicant. Please provide the information below.

ADDITIONAL APPLICANT INFORMATION

What are the strengths of the applicant?

In what area(s) does the applicant require additional support?

What are the preferred items/activities of the applicant?

What are the non-preferred items/activities of the applicant?

What are the applicant’s personal goals?

What are the guardian’s goals?

What is a typical morning like for the applicant?

What is a typical afternoon like for the applicant?

What is a typical evening like for the applicant?

Are there any extracurricular activities that are part of the applicant's typical routine?

Person completing the form:____

Relationship to applicant:______________________________________**Date:**______________

Signature of Applicant:____**Date:**______________

Section 20: Please review the list of required documents to be sent with the complete application.

REQUIRED APPLICATION DOCUMENTS

Document	
Current individual service plan and other related documents	
Documentation of diagnosis from medical professional	
NJ DDD Funding Tier	
Progress notes	
Immunization and Medication Chart	
Referral letter explaining reason for placement	
Assessment reports and related data	
Historical Information	
Medical records and evaluations	
Behavior evaluations	
Current and previous Behavior Support Plans	
Dental Records	
Psychological Evaluations	