

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

Select the region in which you're interested:

☐ Bergen County ☐ Ocean County

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: _____

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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: _____

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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: _____

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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: _____

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Ophthalmologist 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:

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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 a hearing aid(s)

____Wears sunglasses

____Uses a cane

____Wears contact lenses

____Uses crutches

____Cochlear implant

____Uses a wheelchair

____Uses a walker

____Use augmentative and assistive technology for communication

____MAFO

____Other (please describe)

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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:

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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:			

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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	☐	☐	

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

EXPRESSIVE LANGUAGE & COMMUNICATION

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

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 | ☐ Combs/brushes hair independently |
| ☐ Showers independently | ☐ Manipulates fasteners on clothing |
| ☐ Brushes teeth independently | ☐ Shaves independently |
| ☐ Cuts nails independently | |

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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:

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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 | ☐ Mouthing (puts objects in mouth) |
| ☐ PICA (ingestion of inedible objects) | ☐ Self-Injurious behavior |
| ☐ Property destruction/Disruption | ☐ Fecal manipulation/smearing/touching |
| ☐ Cruelty to animals | ☐ Repetitive behaviors |
| ☐ Disrobes/undresses | ☐ Scripting/Non-contextual speech |
| ☐ Scripting/Non-contextual speech | ☐ Self-Stimulatory behaviors |
| ☐ Refusal/Non-compliance | ☐ Theft |
| ☐ Perseveration | ☐ Screaming/loud vocalizations |
| ☐ Dropping | ☐ Makes false allegations towards others |
| ☐ Inappropriate sexual behavior | ☐ Verbal aggression (explicit/inappropriate language) |
| ☐ Inappropriate social behavior | ☐ Forced emesis (vomiting) |
| ☐ Suicidal thoughts, ideations, and/or planning | ☐ Homicidal (thoughts, ideations, and/or planning) |

Other:

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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?

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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?

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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:_____

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

REQUIRED APPLICATION DOCUMENTS

Current Individual Service Plan	
Behavior Support Plan (if applicable)	

OPTIONAL 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	