Able-
SERVICES

Part of the Leg Up Farm Family

APPLICATION FOR ADMISSION / Able Training Center

Name: _____ Date of Birth: _____
first middle last

Address: _____ Age: _____

_____ Sex: _____

Phone #: _____

Race: _____ Religious Affiliation: _____

SSN: _____ Referred By: _____

Name of Parent/Guardian/Emergency Contact: _____

Relationship: _____

Address: _____ _____

_____

Home Phone #: _____

Cell Phone #: _____

Email: _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email

Does anyone have legal guardianship of individual?: ___yes ____no

If yes, name of legal guardian: _____ (attach legal documentation)

Name of Supports Coordinator: _____

Address: _____

_____

Phone #: _____

BSU Number: _____

Funding Source for Day Programming: _____

Approved Staffing Ratio for Day Program: _____

Name of Primary Care Physician: _____

Address: _____

_____

Phone #: _____

Medical Information

Level of Intellectual Functioning: _____

Diagnosis: _____

_____

Date of Most Recent Physical Examination: _____

(If considered for admission, a current physical (within 1 year) will be required. It must include all up to date immunization records (Diptheria/Tetanus within 10 years), a Tuberculin Test (within 2 years), and a statement that person is free of communicable diseases.)

Insurance Name: _____ Policy #: _____

Medicare Number: _____

Current Medications: – Include any occasionally used medication like Tylenol

*A prescription and/or standing order ***signed by a healthcare professional*** is required before we are permitted to administer medication at the day program.

Medication Name	Dosage	Time of Administration

Allergies (to drugs, food, other): _____

Special Diet (describe): _____

Adaptive Aids or Equipment: (please describe if yes)

Hearing Yes ____ No _____ _____

Vision Yes ____ No _____ _____

Mobility Yes ____ No _____ _____

Describe Needs for Support Related to the Following:

Toileting: _____

Eating: _____

Communication Skills – Expressive and Comprehension (include example of verbalizations, tools/methods of communicating, language(s) spoken): _____

_____

Educational Information

High School Name: _____ Date of Graduation: _____

List Individual's Interests, Hobbies, Leisure Activities: _____

_____

_____

Current Programming

Name of Current Day Program: _____

Date of Admission: _____

Describe Current Program Goals/Skill Development: _____

_____

_____

What do you like about your current program? _____

_____

_____

What do you dislike about your current program? _____

_____

_____

Why are you interested in coming to Able-Services' Day Program? _____

_____

_____

It is the policy of Leg Up Farm/Able-Services that we are a smoke free facility. Smoking anywhere on the premises – indoors or outdoors – is strictly forbidden. This includes the use of vaping systems and electronic cigarettes. By submitting this application to be considered for admission, I understand that I will not be able to smoke ***at any time*** while in day programming at Able-Services. Please initial/check the box below acknowledging you understand and agree to this policy.

☐ By initialing/checking this box I certify that I understand the No Smoking Policy Able-Services and agree to abide by this rule as a condition of my admission to the program, if I am accepted.

☐ By initialing/checking this box, I certify that the information contained in this application is true and accurate to the best of my knowledge.

_____

Printed Name of Person Completing This Application

_____ _____

Signature of Person Completing This Application Date

***See List on Reverse for Additional Documentation Needed for Admission**

Other Documentation Needed:

- Emergency Contact Form
- Physical/Immunizations/TB Test/Communicable Disease Statement
    - Attached Physical Form
- Dr.'s prescription for all medication that will be taken during program hours (including OTC medications)
    - Attached Prescription Medication Form (if applicable)
    - Attached Standing Order Form (if applicable)
    - Attached Status of Self-Medication Form (if taking medications at the program)
- Copy of Insurance Card(s)
- Legal Guardianship Documentation (if applicable)
- Copy of current Individual Service Plan
- Current Psychiatric Evaluation, Psychological Evaluation, or IEP