

APPLICATION FOR ADMISSION / Able Training Center

Name: _____ Date of Birth: _____
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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 #: _____

Able-Services, Inc. is a charitable 501(c)(3) organization as provided by Internal Revenue Service requirements. The official registration and financial information of Able-Services, Inc. may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1 (800) 732-0999. Registration does not imply endorsement. This institution is an equal opportunity provider and employer.

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 (Diphtheria/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