

GABRIEL HOMES, INC
P.O. Box 710207, Herndon, VA 20171-0207
703/476-1592 PHONE 703/715-0695 FAX
APPLICATION FOR ADMISSION
 (please print or type)

I GENERAL INFORMATION Date of Application: _____

Applicant's Name: _____ DOB: _____

Current Address: _____ SS#: _____

City: _____ Sex: _____

State, Zip: _____

Applicant's Primary Diagnosis and Date: _____

Applicant's Secondary Diagnosis and Date: _____

Applicant's Legal Status (Guardianship): _____

Referred By: _____ Relationship: _____

I FAMILY

Father's Name & Address: _____	Mother's Name & Address: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Occupation: _____	Occupation: _____
Are Both Parents Living? _____	If not, who is deceased? _____
Are Parents... Together?___ Separated?___ Divorced?___ Remarried (spouse name?) _____	

If Guardian, do you have Power of Attorney? Yes No **** (please attach copy of documentation)**

Siblings Name:	Age:	Address:

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Address: _____ Phone: _____

III. APPLICANT'S PERSONAL SOURCE OF INCOME & AMOUNT

Parental Support _____ SSI _____ Medicaid _____ Family Trust _____

Health Insurance Co. Name: _____

Policy No. and Primary SS #: _____

Secondary Insurance: _____

Policy No.: _____

IV. EDUCATIONAL BACKGROUND (list in chronological order)

Name of School/Facility & Address	Type	Dates Attended

Does the applicant read? _____ If so, what grade level? _____

 ... use arithmetic? _____ If so, what grade level? _____

List occupational skills (computer, phone, office skills) acquired? _____

V. SUPPORT SERVICES

Does applicant receive Fairfax-Falls Church CSB Case Management Services?
If so, provide Case Manager's Name & Phone #: _____

Does applicant currently receive vocational, rehabilitative, residential or other support services (list below)? _____

Provider Name & Type	Phone	Dates of Participation

VI. EMPLOYMENT HISTORY (list in chronological order)

Is Applicant Currently Employed? _____ Where? _____

What Form of Transportation Does Applicant Use: _____

Does applicant use Metro Access Services? _____

Employer	Position Title	Dates	Reason Leaving

VII. MEDICAL HISTORY (PLEASE LIST ALL HEALTH CARE PROVIDER'S USED)

Primary Physician Name _____	Phone: _____
Specialty: _____	Fax: _____
Address: _____	
<hr/>	
Last Medical Exam: _____	Frequency of Check-ups: _____
Specialist Name: _____	Phone: _____
Specialty: _____	Fax: _____
Address: _____	
<hr/>	
Specialist Name: _____	Phone: _____
Specialty: _____	Fax: _____
Address: _____	
<hr/>	
Dentist Name: _____	Phone: _____
Last Visit: _____	Fax: _____
Address: _____	
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PAST MEDICAL HISTORY (Please circle past and present problems or family history with any of the following):

1. High Blood Pressure 2. Diabetes 3. Cancer 4. Heart Disease 5. Shortness of Breath 6. Frequent Urination 7. Incontinence 8. Asthma	9. Bronchitis 10. Pneumonia 11. Persistent Cough 12. T.B. 13. Hay Fever 14. Allergies (specify pg 4) 15. Indigestion 16. Vomiting	17. Diarrhea 18. Constipation 19. Hemorrhoids 20. Thyroid Disease 21. Headache 22. Arthritis 23. Low Back Problems 24. Skins Diseases	25. Blood Disorders 26. Anemia 27. Anxiety 28. Depression 29. Alcohol Abuse 30. Drug Abuse 31. Problems Sleeping
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Comments: _____

IMMUNIZATION & PREVENTION:

Tetanus Hepatitis B Flu Pneumovax Immunization TB Test Other Does applicant wear seat belts ? Does applicant wear a bike helmet ? Does applicant smoke ? Does applicant drink alcoholic beverages?	<table border="0"> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> </table>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When ? _____ When ? _____ When ? _____ When ? _____ When/Results? _____ Frequency ? Frequency ?
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Current Medications	Dosage	Purpose	Prescribed By and When

Allergies (drug, food, environmental, specify): _____
 Special Medical/Physical Limitations: _____
 Special Dietary Needs or Limitations: _____
 Epileptic Seizures/Onset: _____
 Type & Frequency of Seizures: _____
 Past Surgery: _____
 Performed/Dates: _____

VIII. Behavioral/Psychiatric History:

Describe Psychiatric History (Psychiatric Hospitalization: date, duration, reason): _____

Behavioral History:	<i>Please indicate history of the following.....</i>	<i>yes</i>	<i>no</i>
Additional Comments?	History of oppositional/defiant behavior, ignores rules or regulations; difficulty following instructions;		
	History of wandering, leaving for long periods of time, running away;		
	History of Being Disruptive		
	Difficulty respecting boundaries, taking others belonging, distinguishing between honesty/dishonesty		
	History of hyperactivity or restless ness		
	Displays stereotyped behaviors, e.g. rocks body; hands in motion		
	Removes or tears off own clothing		
	Displays sexually inappropriate behavior, (e.g. exposes self, inappropriate touching of self/others)		
	History of use of profane or hostile language		
	History of physical violent to self		
	History of threatening others (verbally or physically)		
	History of Damaging own or others property		
	History of requiring restraint or seclusion (** GHI does not use restraint or seclusion)		

What things agitate applicant? _____

Does/Has Applicant Demonstrate(d) Aggressive Behaviors toward Self/Others?
 If So, Please Describe in Detail: _____

....is He/She Currently receiving treatment?
 If So, Please Describe in Detail: _____

Please Describe Any Other Experiences or Behaviors Which Are Relevant to This Residential Placement: _____

IX. APPLICANT LIVING SKILLS (check the appropriate level of support required to complete task)									
"I" = Performs Independent without any assistance					"V" = Requires Verbal Assistance To Complete Task				
"P" = Requires Partial or Physical Assistance					"U" = Unable To Perform Task				
	I	V	P	U		I	V	P	U
Grooming -bathes/showers					Emergency and Responsibility:				
-teeth (brushes and flosses)					-can identify true emergency				
-hair (washes, rinses and combs)					-contacts 911 (police, fire, poison control)				
-nails, fingers/toes (clean, trimmed)					-contacts doctor, medical assistance				
-shaves (razor or electric)					-contacts another adult/staff member				
-toilets (consider accidents, flushing)					-locks doors when appropriate				
-menses (regular or irregular)					-notifies others when early or late				
-washed hands with soap					-screens visitors				
Clothes: -washes					Medical Needs:				
-dries					-self-medicates accurately and safely				
-folds/hangs					-understands purpose of medications				
-puts away					-obtains prescriptions or refills				
-irons					-schedules medical appointments				
Bedroom/Personal Space: - free of food					-Attends medical appointments				
-vacuums/dusts					-recognizes need for any of the above				
-makes bed and changes linens					-notifies appropriate person of illness				
Household: -vacuums					Financial Management:				
-dusts					-cashes paycheck				
-sweep/mops floors					-budget's expenses w/o falling short				
-empties garbage					-shops for personal supplies/needs				
-wash/dry dishes dishwasher					-pays for social activities				
-cleans sink					-pays bills				
-cleans shower/bathtub					-maintains check book and deposits				
-cleans toilet					-reconciles bank statement				
Meal Preparation:					Time:				
-uses stove/oven					-associates time with various actions/events				
-uses microwave					-understands time equivalents				
-prepares nutritional breakfast					-tells time correctly and understands				
-prepares lunch (sandwiches)					Social Interaction:				
-dinner for self and others					-make friends easily				
-sets table & cleans up after meal					-relates well to members of opposite sex				
-safe with cutlery					-can live with members of opposite sex				
Transportation:					-accept (staff) direction from opposite sex				
-metro bus, including transfers					-respects others				
-metro rail, including transfers					-asks others permission, when appropriate				
-MetroAccess, schedules/pays					-takes care of others' property				

What does the Applicant, Parent or Guardian Expect to Accomplish Through Residential Placement:	
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Name of Person Preparing Application:			
<p>I CERTIFY THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I understand that any false statement, omission, or misrepresentation on this application or in any interview is sufficient cause for refusal to accept applicant for service, or discharge if I have being served, no matter when discovered by Gabriel Homes, Inc. (GHI). Please note that all information is subject to verification.</p> <p>I understand that as part of the determination process a complete review of all medical history will be conducted and that I may be asked to submit to a medical examination. I will request that the Medical Provider's disclose the information directly to GHI, which GHI is to keep according to standard practices of confidentiality.</p> <p>If accepted for placement, I understand and agree to a confidential psycho-social assessment, conducted by GHI's social worker, which will help GHI evaluate my needs and establish a service plan.</p>			
Applicant Signature:		Date:	
Witness:		Date:	
Legal Guardian:		Date:	

Gabriel Homes, Inc. accepts completed applications for placement throughout the year. However, applications will be kept on file until either the applicant withdraws his/her name or a vacancy becomes available. Upon any vacancy, applicants will be contacted to furnish additional information for a thorough and timely review. The documents listed below are required upon active review for placement:

Document	Date Received
- Signed Consent for Release of Information	
- medical records (past 5 years) (immunizations)	
- medication history	
- psychological examinations (2 most recent)	
- vocational records (past 3-5 years, IEP's)	
- employment history, if applicable	
- any other relevant information	

OFFICE USE ONLY:

Date of Receipt: _____

Date of Review: _____

Reviewed By: _____

Date of Interview: _____

Team Decision: _____

Date of Admission: _____

Level of Service: _____

Date of Transfer/Discharge: _____

Reason for Transfer/Discharge: _____

