

Please attach a recent photo

RAINBOW OMEGA, INC.
APPLICATION FOR ADMISSION
P.O. Box 740 Eastaboga, AL 36260

_____/_____/_____
Applicant First Name Middle Name Last Name Date of Birth

Birthplace - City County State

Street Address

City State Zip

(____) _____
Telephone

Marital Status: ___ never married; ___ married; ___ separated; ___ divorced; ___ widowed

Referred to Rainbow Omega, Inc. by _____

Services being sought:
___ Residential Care (which includes vocational training)
___ Respite only
___ Day Vocational Training only

Date Placement Desired:
___ as soon as possible
___ we're wanting to start the process,
 but aren't needing placement right away

Nature of disability (i.e., mental retardation, autism, cerebral palsy, brain injury, Down syndrome, etc.):

Date diagnosed: _____

Please list three persons who have worked with or known the applicant personally.

a) Name _____ Phone (____) _____
 Address _____
 Relationship: ___ family ___ friend ___ teacher ___ church ___ school ___ therapist

b) Name _____ Phone (____) _____
Address _____
Relationship: ___ family ___ friend ___ teacher ___ church ___ school ___ therapist

c) Name _____ Phone (____) _____
Address _____
Relationship: ___ family ___ friend ___ teacher ___ church ___ school ___ therapist

I. FAMILY & SOCIAL INFORMATION

1. Father's Name _____

Home Address _____
Street City State Zip

Home Phone: (____) _____ Business Phone: (____) _____

Occupation & Name of Company _____

If deceased? Date: _____ Age: _____

Cause: _____

2. Mother's Name _____

Maiden Name: _____

Home Address _____
Street City State Zip

Home Phone: (____) _____ Business Phone: (____) _____

Occupation & Name of Company _____

If deceased? Date: _____ Age: _____

Cause: _____

7. What is the applicant's primary mode of communication with others (e.g., speech, sign language, gestures, etc.)?

8. How does the applicant interact with friends and family:

9. Religious Affiliation: _____

10. What is the applicant's current schedule:

Morning: Gets up at _____.

Afternoon:

Evening:

Night:

Goes to bed at _____

11. Likes and Dislikes:

	Likes	Dislikes
Food		
TV		
Music		
Sports		

Outside Activities		
Restaurants		
Games		
Other		

II. SCHOOLS AND PROGRAMS ATTENDED

- Applicant earned a high school diploma
- Applicant earned a certificate of completion from high school
- Applicant is still attending high school

Check all situations in which the applicant has participated. Please complete the information requested for each program.

- a. Group Home
- b. Independent Living
- c. State Institution
- d. Public Schools
- e. Competitive job
- f. Rehabilitation program
- g. Pre-vocational training
- h. Sheltered Workshop
- i. Day program
- j. Other _____

1) Name _____ Dates _____
 Address _____
 Type Program (from above list) _____
 Reason for leaving _____
 Contact Person _____
 Phone _____

2) Name _____ Dates _____
 Address _____
 Type Program (from above list) _____
 Reason for leaving _____
 Contact Person _____
 Phone _____

3) Name _____ Dates _____

Address _____

Type Program (from above list) _____

Reason for leaving _____

Contact Person _____

Phone _____

III. ACTIVITIES OF DAILY LIVING

1. Hygiene

- | | | |
|-------------------|--------------------------------------|--|
| a. showering | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| b. brushing teeth | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| c. shaving | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| d. toileting | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |

2. Dressing

- | | | |
|-------------------------|--------------------------------------|--|
| a. picking out clothing | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| b. putting on clothing | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |

3. Laundry

- | | | |
|------------------------------|--------------------------------------|--|
| a. sorting lights from darks | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| b. setting the controls | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| c. pouring the detergent in | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| d. folding clothing | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |
| e. hanging clothing | <input type="checkbox"/> independent | <input type="checkbox"/> assistance needed |

4. Handling/Understanding money

- | | | |
|--------------------------------------|-----------------------------|------------------------------|
| a. can identify coins and bills | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| b. understands the value of money | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| c. understands how to make purchases | <input type="checkbox"/> no | <input type="checkbox"/> yes |

5. Meals

- | | | |
|---|-----------------------------|------------------------------|
| a. can hold spoon/fork and eat without assistance | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| b. can hold glass and drink without assistance | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| c. can cut his/her food | <input type="checkbox"/> no | <input type="checkbox"/> yes |

6. Preparing food

- | | | |
|--|-----------------------------|------------------------------|
| a. can prepare a simple item like a sandwich | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| b. knows how to use a microwave | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| c. knows how to use an oven | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| d. knows how to use the stove | <input type="checkbox"/> no | <input type="checkbox"/> yes |

7. Chores

- a. can keeps room clean ___ no ___ yes
- b. knows how to
 - sweep ___ no ___ yes
 - mop ___ no ___ yes
 - dust ___ no ___ yes
 - load dishwasher ___ no ___ yes
 - unload dishwasher ___ no ___ yes
 - wipe off table/counters ___ no ___ yes
 - fold towels ___ no ___ yes

IV. MEDICAL INFORMATION

The applicant or the applicant’s guardian, parents or physician should complete the following information. All information is strictly confidential and will not be used for any purpose other than to guide Rainbow Omega, Inc. in providing care for the applicant. The information will not be released to any other facility, agency, or individual without the expressed written consent of the legally competent applicant or the guardian, parent, or responsible relative of an adjudicated incompetent applicant, or the legal agent holding power of attorney for an applicant.

1. Required Immunizations

Measles: Had measles or vaccinated with live measles vaccine since 1968. ___ no ___ yes

Mumps: Had mumps or vaccinated with live vaccine after 12 months of age. ___ no ___ yes

Rubella: Had rubella or vaccinated after 18 months of age. ___ no ___ yes

Tetanus & Diphtheria: Vaccinated first with a series of 3 doses (2nd dose 4-8 weeks after 1st dose; 3rd dose 6-12 months after 2nd dose). ___ no ___ yes

Date of last booster _____.

Polio: Series of Trivalent Oral Polio (OPV) vaccine at 2, 4, & 18 months of age or taken 4 doses of Inactive Polio Vaccine (IPV), continued IPV every 5 years until 18 years of age. ___ no ___ yes

Tuberculosis: Date of last negative chest X-ray or Tine Test: Date _____

Has applicant received flu vaccine before? ___ no ___ yes
If so, date _____

Has applicant received pneumococcal vaccine? ___ no ___ yes
If yes, date _____

Has applicant received 3 doses Hepatitis B vaccine? ___ no ___ yes
If yes, date _____

2. Sex _____ **Height** _____ **Weight** _____

3. Blood Type (if known) _____

4. Allergies:

Medication allergies _____

Food allergies _____

Allergy to pollens, insect bites, skin contact, substances? allergies _____

If on medication/injection for allergies, give name of physician, medication/injection dose and frequency. _____

5. Diet:

Is the applicant on any special diet (i.e., low calorie, low fat, diabetic diet, etc.)? ___ no ___ yes

If yes, was the diet recommended by his/her physician? ___ no ___ yes

If the applicant is on a diet, please describe it: _____

6. Health History

If you answer yes to any of the following, please give details. Use extra pages if necessary.

Condition	No	Yes	Details
Heart Trouble	___	___	_____
Frequent Cold/Sinus Trouble	___	___	_____
Headaches	___	___	_____
Visual Problems	___	___	_____
Glasses	___	___	_____
Hearing Problems	___	___	_____
Hearing Aid	___	___	_____
Frequent Chest Infection	___	___	_____
Asthma	___	___	_____
Epilepsy	___	___	_____
Tuberculosis	___	___	_____
Kidney Disease	___	___	_____
Obesity	___	___	_____
Anemia	___	___	_____
Stomach Trouble	___	___	_____
Diabetes	___	___	_____
Diarrhea	___	___	_____

Fainting Spells ___ ___ _____
 Menstrual Problems ___ ___ _____
 Muscle Problems ___ ___ _____
 Neurological Problems ___ ___ _____
 High Blood Pressure ___ ___ _____
 Other significant problems ___ ___ _____

7. Medications:

Medications	Dosage	Frequency	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Can the applicant swallow pills or does he/she need them crushed?

___ swallow whole ___ needs them crushed

9. Physicians

Primary Care Physician: _____

Address: _____

Phone number: _____

Dentist: _____

Address: _____

Phone number: _____

Ophthalmologist (vision): _____

Address: _____

Phone number: _____

Other: _____

Address: _____

Phone number: _____

10. Does the applicant have a fear of doctor or dental appointments or shots (beyond what's normal for most individuals)? no yes

If yes, please describe what helps: _____

11. Does the applicant have any of the following:

Prosthesis (eye, leg, etc.) no yes

If yes, please give details - _____

Wheelchair no yes

Cane no yes

Dentures no yes

If yes, are they: upper lower both

Hearing aids no yes

If yes, are they: right left both

Other _____

12. Past Surgeries, Hospitalizations, and major illnesses or injuries

Please indicate any past surgeries, hospitalizations, and major illnesses or injuries such as appendectomy, spinal meningitis, broken arm, etc. and dates they occurred.

13. Family Medical History

Has any member of the family ever had or been treated for any of the following: If yes, please explain and tell how they are related to the applicant.

Heart trouble: no ___ yes _____

Lung trouble: no ___ yes _____

High blood pressure: no ___ yes _____

Low blood pressure: no ___ yes _____

Stomach trouble (i.e. ulcers): no ___ yes _____

Diabetes: no ___ yes _____

Kidney trouble: no ___ yes _____

Cancer: no ___ yes ___ type _____

Thyroid trouble: no ___ yes _____

Glaucoma: no ___ yes _____

Epilepsy: no ___ yes _____

Blood disorders or "free bleeding": no ___ yes _____

Hepatitis: no ___ yes _____

Nervous system (seizures, strokes, etc.): no ___ yes _____

Other: _____

14. Other Factors

Are there other medical factors, which would influence the care, health, and well-being of the applicant? ___ no ___ yes If yes, please describe:

Were there any problems with the pregnancy or birth of the applicant?

___ no ___ yes If yes, please describe:

V. PSYCHOLOGICAL / BEHAVIORAL

1. Has the applicant had a Psychological Evaluation?

If yes, what is the date the evaluation was done and what was the Full Scale IQ (FSIQ)?

Date: _____ FSIQ: _____

Reminder: We need a copy of a Psychological Evaluation performed after the age of 18 sent with this application.

2. Does the applicant receive care from a therapist, psychologist, or psychiatrist? ___ no ___ yes

If yes, please describe why: _____

3. Does the applicant have any psychiatric diagnosis, other than his/her developmental disability (e.g., depression, anxiety, schizophrenia, insomnia, etc.)? ___ no ___ yes

If yes, please state: _____

4. Has the applicant ever had any physically aggressive behavior (e.g., hitting, kicking, biting, etc.)? ___ no ___ yes

If yes, please describe: _____

5. Does the applicant ever become verbally aggressive (e.g., cursing, threatening, etc.)? ___ no ___ yes

If yes, please describe: _____

6. Describe how the applicant handles situations that make him/her sad:

7. Describe how the applicant handles situations that make him/her angry:

8. Describe what you believe is the most effective way of helping when the applicant is angry or sad:

9. Describe what you believe is the least effective way of helping when the applicant is angry or sad:

10. Does the applicant have any great fears or phobias (e.g., heights, the dark, loud noises, spiders)?
___ no ___ yes

If yes, please describe: _____

VI. VOCATIONAL

1. Has the applicant ever had job training? ___ no ___ yes
If yes, where and when:

Name: _____

Dates: _____

Name: _____

Dates: _____

2. Has the applicant ever held a job? ___ no ___ yes

If yes, where and when:

Name: _____

Dates: _____

Name: _____

Dates: _____

3. Can the applicant write? ___ no ___ yes

If yes, how well? _____

4. Can the applicant read? ___ no ___ yes

If yes, how well? _____

VII. FINANCIAL

Please be assured all information is strictly confidential and will only be shared with the business office in order to help determine finances.

1. Does the applicant receive any of the following monthly benefits?:

SSI: \$ _____ SS/SSA: \$ _____ Other: \$ _____

(if other, please explain: _____)

2. Does the applicant currently have a bank account in their name? ___ Yes ___ No

(If yes, is the balance greater than \$2,000? ___ Yes ___ No

3. Does the applicant have any assets or funds in their name? ___ Yes ___ No

(ie: property, land, cars, stocks, bonds, insurance policies, etc)

4. Does the applicant have a Trust Fund for their benefit? ___ Yes ___ No

5. What type of medical/insurance coverage does the applicant have?

___ Medicare ___ Medicaid ___ Other

Medicare # _____ Medicaid # _____

(if other, please describe _____)

6. Provided parent/guardian becomes deceased, who is appointed role of responsibility for the applicant? (Please give name, address, phone number, and relationship to applicant).

Name: _____

Address: _____

Phone Number: _____ Alt phone number: _____

7. Use this space to describe any special problems you have had in finding assistance or benefits for the applicant? _____

Do you know anything else special about your child that would assist us in providing the best possible care for him/her?

I affirm that the information contained in this application is, to the best of my knowledge and belief, a complete and true statement of facts and circumstances relative to the applicant and family.

Signature/Mark of Applicant

Date

Signature of Parent/Guardian/Family Member

Date

Signature of person completing the application
if different from above.

Date