FAISON ADULT SERVICES: ADMISSIONS
1701 Byrd Avenue
Richmond, VA 23230
804-612-1947
www.faisoncenter.org

CLIENT HISTORY, APPLICATION AND INITIAL ASSESSMENT FORM

Please complete and return this form to the address above.

Please Complete the Following Application and Provide These Additional Items-

Applications will not be considered complete until all items are received

1) Physical examination (completed within the last 90 days), immunization record, TB test from within 1 year: Required
2) Most recent/current IEP or ISP (DMAS form 457 or Part IV of Shared Planning): Required
3) Most recent assessment from a transition service (i.e. From DARS, the Choice Group, etc.), if applicable
4) Most recent/current Behavior Intervention Plan, if applicable
5) Most recent educational and psychological evaluations, from within the last 5 years, if applicable
6) Guardianship, Conservatorship or Power of Attorney documentation: Required

Note: Psychological Evaluations are required if individual has a Mental Health Diagnosis

The team will review this form and accompanying documents. After reviewing this information we will contact you to set up an intake appointment. If you should have any questions or need assistance, please contact us at 804-612-1947. Thank you very much for your assistance!

Parent Prefers Review for (circle all that apply):

Residence Services Community Based Adult Day Services Family Partner Program

Completed By _____ **Date Completed** _____

Relation to Applicant _____

Address _____

Telephone _____ **Email** _____

Parents'/Guardians' Names _____

Mother's Address _____

Father's Address _____

Guardian's Address _____

PART I - BIOGRAPHICAL INFORMATION

Applicant's Name (i.e., person in need of services) _____

Date of Birth_____ **County of Residence** _____

Gender (circle): Male Female **Does the applicant live with you?** _____

If not, please specify name of group home/residential facility _____

Address of Residential/Group Facility _____

Contact Person at Facility_____**Telephone** _____

Current Day Program_____**Telephone** _____

Address _____

School the Applicant Graduated/Will Graduate From_____
Projected or Actual Year of Graduation:_____

IQ Score:_____ **Year IQ Testing was Completed:**_____

Who is the Individual's Legal Guardian (circle one)?
Applicant (has own rights) Parent/Guardian Other

Do You Have the Legal Guardianship Documentation? _____
Note: Guardianship paperwork is REQUIRED if it is indicated the applicant is not his/her own guardian.

Who is the Applicant's Case Manager?
Name_____ Telephone_____
Agency_____

Does the Applicant Have Medical Insurance? _____

Name of Insurance Provider_____

Policy# and Subscriber Name _____

Group# _____

If through the parent, by what means do you/they access this health insurance?_____

If through work, please list company name _____

Primary Care Physician_____**Telephone** _____

Address _____

Other Physician(s)_____**Telephone** _____

Address _____

What method(s) of funding will be used to pay for the Adult Services (circle all that apply)?)

Private DD Waiver ID Waiver DARS SSI Other:_____

PART II -- PREVIOUS WORK, LIVING AND DAY SUPPORT PROGRAMS

List the most recent paid or volunteer jobs the applicant has completed:

Job Title_____Company/Organization_____
Was the position paid, volunteer or both?_____Dates position held_____
Is the applicant eligible to be rehired with the company/organization? _____

Job Title_____Company/Organization_____
Was the position paid, volunteer or both?_____Dates position held_____
Is the applicant eligible to be rehired with the company/organization? _____

Job Title_____Company/Organization_____
Was the position paid, volunteer or both?_____Dates position held_____
Is the applicant eligible to be rehired with the company/organization? _____

List applicant's previous living arrangements:

Previous Address:_____Dates_____
Who lived with the applicant at this address (circle): Parent Caretaker Group Home Staff Other
Name of Residence (if applicable)_____
Why did the applicant move or why was the applicant discharged? _____

Previous Address:_____Dates_____
Who lived with the applicant at this address (circle): Parent Caretaker Group Home Staff Other
Name of Residence (if applicable)_____
Why did the applicant move or why was the applicant discharged? _____

List previous day programs in which the applicant was enrolled:

Name of Program_____Dates attended_____
Address_____
Why did the applicant discharge from this program?_____

Name of Program_____Dates attended_____
Address_____
Why did the applicant discharge from this program?_____

Has the applicant received previous vocational, pre-vocational, daily living skills, etc. training?
No Yes
Specify training, including dates and training agencies:_____

PART III - PSYCHOSOCIAL/DEMOGRAPHIC BACKGROUND

Caregiver's Name	Age	Occupation	Marital Status
Father			
Mother			
Guardian			

Mother - Race/Ethnicity (circle one)

White Black/African American Hispanic/Latino Asian American Indian/Alaskan Native Other

Father - Race/Ethnicity (circle one)

White Black/African American Hispanic/Latino Asian American Indian/Alaskan Native Other

Mother - Income (circle one)

Less Than $24,999 $25,000-$49,999 $50,000-$74,999 $75,000-$99,999 $100,000+

Father - Income (circle one)

Less Than $24,999 $25,000-$49,999 $50,000-$74,999 $75,000-$99,999 $100,000+

Education Level	Father	Mother
Less than 9th Grade		
9th to 12th Grade - No Diploma		
High School Diploma or GED		
Associate Degree		
Bachelor Degree		
Graduate or Professional Degree		

Who Lives in the Applicant's Residence?

Name	Age	Gender	Relationship

What is the Primary Language Spoken in the Home? _____

Please List Community Agencies/Contacts Who Provide Services to the Applicant

Agency	Contact Name	Telephone	Nature of Service

PART IV - MEDICAL

General Information

List All Previous and Current Psychiatric and/or Developmentally-Related Diagnoses/Problems

_____

_____

_____

List All Previous and Current Medical Diagnoses/Problems

_____

Diagnosing Physician or Other Professionals **Specialty, Area of Expertise, etc.**

_____

_____

List Medical Equipment and/or Treatments (tube feeds & pump, tracheotomy, CPAP, etc)

_____

_____

_____

ALLERGIES (Food, Medication, and Environmental)

Allergen	What Symptoms Occur with	Treatment for	Formally Tested or

Medication

List All Information for Each *Current* Medication

Drug Name	Date Started	Dosage	Purpose	Has It Been Effective?

List Any Topical Medications (creams and ointments) _____

What Other Medications Have Previously Been Prescribed But Are No Longer Being Administered?

_____

_____

_____

Hospitalizations, Testing & Evaluations

Hospitalization

Hospital Name	Month/Year	Reason

Surgeries		
Hospital Name	**Month/Year**	**Reason**

NEUROLOGICAL

Is There a History of Seizures? _____ Age of Onset _____ Date of Last Seizure _____

How Often Does Seizure Occur Now and How Long Does it Last _____

Describe What Seizure Activity Looks Like _____

_____

Describe Other Neurological Problems _____

_____

Date of Last EEG, MRI or CT Scan (if applicable) _____

Date of Last Neurologist Visit _____

Physician's Name_____Telephone _____

EYES

Are There Any Problems with Vision? _____ If Yes, Explain _____

Glasses (Y or N)? _____ How Often Are Glasses Worn? _____

What issue do the corrective lenses address? _____

Date of Last Eye Exam (if applicable)_____Seen By (circle) Ophthalmologist Optometrist

Physician's Name_____Telephone _____

EARS, NOSE & THROAT

Are There Any Problems with Hearing? _____ If Yes, Explain _____

Hearing Aid (Y or N)? _____ How Often Is Hearing Aid Worn? _____

Past Ear Infections_____If Yes, Explain _____

Date of Last ENT Exam (if applicable) _____

Physician's Name_____Telephone _____

DENTAL

Are There Any Problems with Current Condition of Teeth? _____ If Yes, Explain _____

_____

Date of Last Dental Exam _____

Past Dental Procedures & Dates _____

_____

ADDITIONAL SPECIALISTS (Cardiology, Urology, Orthopedics, GYN, etc)

Physicians Name	Specialty	Telephone	Reason for Being Seen

OTHER PREVIOUS MEDICAL TESTS & EVALUATIONS (List Type & Date)

Chromosomes _____
Metabolic Studies _____
Feeding/Swallowing _____
Gastrointestinal _____
Other _____

PART V - NUTRITION

Current Weight _____ Current Height _____

Diet (Circle) - Regular Chopped Pureed Low Fat Other _____

Describe Any Feeding Problems (chewing, swallowing, choking, eating too fast, vomiting, food aversions, etc) _____

_____

Does the applicant take any nutritional supplements? _____
If so, please list _____

PART VI - MALADAPTIVE BEHAVIOR

Record each maladaptive behavior the applicant displays and describe it specifically. Include any damage resulting from the problem behavior either to the individual, others and property. Please rank in order of concern to yourself or to other caretakers.

Behavior	Description	Occurs How Often	Damage to Self/Others/Property

Estimate the Severity of the Behavior of Greatest Concern (Circle One)
Minor Moderate Severe Life Threatening

Has the Applicant Ever Been Sent to the Hospital to Treat an Injury Resulting from the Behavior?
Yes _____ No _____
If Yes, Describe _____

Has the Applicant Ever Injured Someone In Such a Way That Required Them to Seek Medical Treatment?
Yes_____ No_____
If Yes, Describe _____

Has the Applicant Ever Been Hospitalized to Develop a Treatment for These Behavior Problems?
Yes_____ No_____
If Yes, Describe _____

In What Setting Does Problem Behavior Occur (Circle)
Home Day Program Community Other
If Other, Describe _____

How Long Has the Applicant Been Engaging in the Maladaptive Behavior (circle one)?
Within Past 6 Months
More than 6 Months, But Less than 1 Year
More than 1 Year, But Less than 3 Years
More than 3 Years, But Less than 5 Years
More than 5 Years, But Less than 10 Years
More than 10 Years

When is Maladaptive Behavior Likely to Occur (circle all that apply)
When Individual is Left Alone or Unattended When the Individual Cannot Have Something He/She Wants
When Lots of People are Around
Time of Day
When Demands are Placed on the Individual
Other _____
Mealtimes, Dressing or Bathing

Are There Any Situations or Environments, When the Behavior Rarely or Never Occurs?

_____

_____

How Do People (Parents, Staff, Etc) Typically Respond When the Individual Engages in Maladaptive Behavior? _____

_____

Is a Formal Program or Intervention Protocol Currently Being Used? Yes _____ No _____
If Yes, Please Include With This Application
How Long Has the Program Been in Place? _____

Estimate the General Trend of Maladaptive Behavior During the Past Year (circle one)
Increasing (Behavior Getting Worse) Stable (About the Same) Decreasing (Improving)

Does the Applicant Display Aggressive Behavior Toward Staff or Peers? Yes _____ No _____
If Yes, Explain _____

Was the Onset of the Maladaptive Behavior(s) Associated with any Specific Event or Series of Events?

_____

Have the Following Procedures Ever Been Used to Treat the Maladaptive Behavior(s)?

Restraint (describe) _____
Which Behavior was the Treatment Indicated for? _____
Start Date_____Still Used (Yes/No)_____Stop Date _____
Degree of Success - Poor_____Fair_____Good_____Excellent _____

Protective Equipment (helmet, gloves, etc.) _____
Which Behavior was the Treatment Indicated for? _____
Start Date_____Still Used (Yes/No)_____Stop Date _____
Degree of Success - Poor_____Fair_____Good_____Excellent _____

Positive Reinforcement Procedures (describe) _____
Which Behavior was the Treatment Indicated for? _____
Start Date_____Still Used (Yes/No)_____Stop Date _____
Degree of Success - Poor_____Fair_____Good_____Excellent _____

Time Out (describe) _____
Which Behavior was the Treatment Indicated for? _____
Start Date_____Still Used (Yes/No)_____Stop Date _____
Degree of Success - Poor_____Fair_____Good_____Excellent _____

Corporal Punishment, Spanking, etc. (describe) _____
Which Behavior was the Treatment Indicated for? _____
Start Date_____Still Used (Yes/No)_____Stop Date _____
Degree of Success - Poor_____Fair_____Good_____Excellent _____

Other (describe) _____
Which Behavior was the Treatment Indicated for? _____
Start Date_____Still Used (Yes/No)_____Stop Date _____
Degree of Success - Poor_____Fair_____Good_____Excellent _____

Have alternative treatments and/or therapies been used, past or present? Check One and/or List All

Alternative Therapy/Interventions	**Name of Prescribing Physician/Professional**	**Date Initiated**
Gluten and/or Casein Diet		
Hyperbaric Chamber Treatment		
Chelation		
Sensory Integration		
Music Therapy		
Dance Therapy		
Other		

PART VII - CURRENT SKILLS

Please score the items below using the number that most closely describes the applicant's ability.
If the item is not applicable, please indicate with NA.
1 - Cannot Perform Skills Independently or Correctly
2 - Requires Much Assistance to Perform Skill Correctly
3 - Requires Some Assistance to Perform Skill Correctly
4 - Performs Skill Independently and Correctly

Toileting		Mobility		Bathing		Dressing	
Has Bowel Movement in Toilet		Walks		Gets in Bathtub		Put on Undergarments	
Urinates in Toilet		Moves out of dangerous situation(i.e. fire alarm)		Takes a Shower		Put on Shirts and Pants	
Pull Ups/Diapers During Day		Wheelchair		Can Wash Self		Uses Zippers and Buttons	
Pull Ups/Diapers During Night		Braces		Can Brush Teeth		Put on shoes	
Washes Hands After Toileting		Walker		Can Brush Hair		Put on a bathing suit	

Put an "X" Next to the Best Description of the Individual's Food Consumption Skills, Sleep Habits, and Communication Skills

Food Consumption Skills	Consistently	Sometimes	Never
Needs to be Fed			
Throws/Plays with Food			
Properly Uses a Spoon			
Properly Uses a Fork			
Drinks From a Cup			

Preservation Skills	Consistently	Sometimes	Never
Drives			
Uses public transportation			
Manages own money			
Purchases needed items (i.e. food)			
Navigates community locations (i.e. stores)			
Initiates leisure trips outside of the house			
Demonstrates street safety			
Demonstrates stranger safety			

Exercise and Leisure Skills	Consistently	Sometimes	Never
Engages in cardiovascular exercise			
Engages in strength exercises			
Engages in stretching exercises			
Visits the gym			
Uses gym equipment (i.e. treadmill, bike)			
Swims			
Reads or looks at books			
Engages in leisure activity without adult supervision for 5 minutes or more			

Sleeping Habits	Consistently	Sometimes	Never
Trouble Falling Asleep			
Sleeps Throughout Night			
Difficulty Waking in Morning			
Early Waking			
Sleep Apnea			
Snoring			

Time to Bed (PM) _____

Time to Wake (AM) _____

Communication Skills	Consistently	Sometimes	Never
Speaks Freely and Easily			
Talks Mainly in Phrases			
Uses Single Words			
Communicates with Gestures			
Uses Sign Language			
Communicates with Pictures			
Writes/Prints			
Understands Simple Questions			
Follows Simple Commands/Instructions			
Can Imitate a Model			

If Using an Augmentative Communication Device, Provide Name of Device _____

What Frequency/Type of Supervision is Required (circle one)?

Constant (1-on-1) Individualized (small group) Large Group Completely Independent

Can be Left Alone for Brief Periods - Yes _____ No _____

Needs Continuous Monitoring But Can Work in a Group - Yes _____ No _____

Does the Applicant Appear to Enjoy Social Interaction - Yes _____ No _____

Specify _____

Please List Preferred Foods/Activities

Favorite Foods _____

Favorite Items _____

Favorite Activities _____

Favorite Types of Social Interaction _____

Are there certain items, activities, places, or environments that the applicant does not like? If so, please list.

_____

Please Add Any Other Details You Feel Would Help Us Serve the Applicant

_____

_____

_____

_____

_____

_____