

APPLICANT INFORMATION		
Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
PARENT/CONSERVATOR		
Name:		
Address:		
City:	State:	ZIP Code:
Phone:	Email:	
FAMILY/EMERGENCY CONTACT		
Name:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
PHYSICIANS/SPECIALISTS		
PCP (Phone & Address):		
MD (Phone & Address):		
Psychiatrist (Phone & Address):		
DDS (Phone & Address):		
MEDICAL DIAGNOSES/TYPES OF DISABILITY		
MEDICATIONS		
ALLERGIES	ASSISTIVE DEVICES	
SIGNATURES		
Signature of applicant:		Date:
Signature of parent/conservator:		Date:

## REGISTRATION FORM

(Please Print)

Today's date:			Referred By:				
APPLICANT INFORMATION							
Applicant's last name:		First:	Middle:	Height:	Weight:	Primary Disabling Condition:	
School or Service Provider:		Teacher or Service Provider Contact:			Birth date:	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Home Phone #: (    )		Social Security #:		
City:	State:			ZIP Code:	State Id #:		
Parent/Conservator:	Email:			Cell Phone #: (    )			
Please consider me for the following Breakthrough Programs:		<input type="checkbox"/> Day Services	<input type="checkbox"/> Personal Assistance	<input type="checkbox"/> Respite Care	<input type="checkbox"/> Respite & Recreation	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Supported Living

HEALTH INFORMATION		
<i>(To be filled out by the Parent/Conservator)</i>		
Primary Care Physician:	Phone #: (    )	Address:
Psychiatrist:	Phone #: (    )	Address:
Dentist:	Phone: (    )	Address:
Other Specialist:	Phone: (    )	Address:
Medical History: (Hospitalizations, Illnesses, Emergency visits, Surgeries, etc.)		
Does your son or daughter have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list below:	Does your son or daughter have seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please answer the following questions.	What typically happens before a seizure?
	Date of last seizure:	What steps are taken at home during/after a seizure?
	Type: Frequency:	Anything else we should know regarding his/her seizures?

## HEALTH INFORMATION (CONTINUED)

Preventative Medical Care Issues:

Acute Medical Care Issues:

Chronic Medical Care Issues:

Diagnostic Specific Medical Care Issues:

Dental Issues:

Date of Last Immunizations:	<input type="checkbox"/> Seasonal Flu _____ <input type="checkbox"/> H1N1 _____	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Hepatitis B _____	<input type="checkbox"/> Pneumovax _____
Date of Last Tuberculosis Skin Test: _____ Positive _____ Negative _____ Unsure _____	<input type="checkbox"/> Hepatitis B: Primary- 3 shots _____ Booster _____	<input type="checkbox"/> Measles, Mumps, & Rubella: _____	<input type="checkbox"/> Other: _____ _____ _____	

### FUNCTIONAL & BEHAVIORAL HEALTH INFORMATION

*(To be filled out by Parent/Conservator)*

<b>Vision:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Low vision <input type="checkbox"/> Wears glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Blind <input type="checkbox"/> Other _____	<b>Hearing:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Wears hearing aid <input type="checkbox"/> Deaf <input type="checkbox"/> Wears earplugs/headphones <input type="checkbox"/> Other _____	<b>Communication:</b> <input type="checkbox"/> Able to communicate <input type="checkbox"/> Uses verbalizations/vocalizations <input type="checkbox"/> Uses gestures/signs <input type="checkbox"/> Not able to communicate needs <input type="checkbox"/> Other _____	<b>Dining/Eating:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Small bites <input type="checkbox"/> Verbal prompting <input type="checkbox"/> Chopped <input type="checkbox"/> Hand over hand assistance <input type="checkbox"/> Other _____
<b>Toileting Ability:</b> <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Needs assistance <input type="checkbox"/> Pull-ups <input type="checkbox"/> Diapers <input type="checkbox"/> Other _____	<b>Ambulation:</b> <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady <input type="checkbox"/> Needs assistance <input type="checkbox"/> Other _____	<b>Response to Medical Exams:</b> <input type="checkbox"/> Cooperates <input type="checkbox"/> Partial cooperation <input type="checkbox"/> Fearful <input type="checkbox"/> Resistant <input type="checkbox"/> Non-compliant <input type="checkbox"/> Other _____	<b>Pain Response:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Unique (please explain _____)
<b>Dressing Ability:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Needs verbal cues and/or prompts <input type="checkbox"/> Hand over hand assistance <input type="checkbox"/> Full assistance <input type="checkbox"/> Other _____	<b>Following Directions:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Needs Verbal cues and/or prompts <input type="checkbox"/> Needs physical prompts <input type="checkbox"/> Other _____	<b>Socialization:</b> <input type="checkbox"/> Will independently engage with others <input type="checkbox"/> Needs verbal cues and/or prompting to engage with others <input type="checkbox"/> Needs physical prompts to engage with others <input type="checkbox"/> Prefers engaging with peers who are non-disabled <input type="checkbox"/> Other _____	<b>Safety:</b> <input type="checkbox"/> Has appropriate response to unsafe situations <input type="checkbox"/> Needs increased supervision in public for potential safety concerns <input type="checkbox"/> Must be in constant supervision due to overall lack of awareness of unsafe situations <input type="checkbox"/> Other _____

<b>(Females only)</b> Menstrual Periods: <input type="checkbox"/> Yes <input type="checkbox"/> No  Typical Symptoms: _____ _____ _____ _____ _____ _____ _____	<b>Precautions, modifications, and/or adaptations that you think may benefit your son or daughter during activities:</b> _____ _____ _____ _____ _____ _____ _____	<b>Please list any physical activities that your son or daughter <i>SHOULD NOT</i> participate in:</b> _____ _____ _____ _____ _____
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**Is your son or daughter prone to emotional upsets?**  Yes  No If so, please explain.

**Does your son or daughter exhibit any unusual or out of the ordinary behavior when he or she becomes very excited, overly tired, frustrated, or agitated?**  Yes  No If so, please explain.

**Has your son or daughter ever had incidents of aggression towards others?**  Yes  No If yes, please answer the questions below:

- Less than 5 incidents per month of minor aggression (verbal or physical, but no injuries) towards others
- More than 5 incidents per month of aggression without injury to others
- Less than 5 episodes of aggression per month with minor injuries to others (injuries not needing medical attention)
- More than 5 episodes of aggression requiring increased supervision, interventions, and/or staffing ratios

**Has your son or daughter ever had incidents of property destruction?**  Yes  No If yes, please answer the questions below:

- Less than 5 incidents per month of aggression resulting in minor property destruction
- More than 5 incidents per month of aggression resulting in minor property destruction
- Less than 5 episodes of aggression per month resulting in moderate property destruction
- More than 5 episodes of aggression resulting in significant property destruction requiring increased supervision, interventions, and/or staffing ratios

**Has your son or daughter had incidents of self-abuse?**  Yes  No If yes, please answer the questions below:

- Minimal self-abuse
- Self-abuse occurs less than 2 times per month
- Self-abuse occurs more than 2 times per month
- Self-abuse occurs frequently – needs frequent monitoring

### AREAS OF INTEREST

*(Please describe preferred activities below.)*

Music:	
Swimming:	
Art:	
Sports:	
Cooking:	
Computers:	
Reading:	
Exercise:	
Movies:	
Sensory:	
Volunteering:	
Vocational:	
Activities of Daily Living:	
Other Indoor Activities:	
Other Outdoor Activities:	

### FINANCIAL

*(To be filled out by Parent/Conservator)*

My son or daughter receives Medicaid funded Waiver Services through the Division of Intellectual Disability Services.  Yes  No

If yes, please select the appropriate one below.  
 Arlington Waiver  State-Wide Waiver  
 Self-Determination Waiver

Are you interested in learning more about private pay options for services?  
 Yes  No

Please note, if your son or daughter currently receives Waiver funds and has approved PA hours, he or she may be eligible to use some of these hours for our Respite and Recreation program on Saturdays. We would be happy to speak to you regarding this arrangement.

### SIGNATURES

Parent/Conservator:	Date:
Applicant:	Date: