



Residential Services, Inc.
Application for Admission

Please Return to: Residential Services, Inc.
111 Providence Road
Chapel Hill, NC 27514
Attn: Social Worker

Telephone: (919) 942-7391
FAX: (919) 933-4490
Email: Mail@rsi-nc.org

If the applicant is his/her own guardian, he/she must sign this application. If the applicant has a legal guardian or guardians, the legally responsible person(s) must sign to confirm agreement with the application.

Date of Application: _____

Applicant's Full Name: _____

Preferred name: _____ Social Security #: _____
Optional / Required upon admission

Address: _____
Street City County State Zip

Gender: M F Place of Birth: _____ Date of Birth: _____

Primary language of Applicant (e.g. English, Spanish, Sign, etc): _____

Primary language of Parent/Guardian: _____

Briefly state reason(s) for seeking admission:

Please describe the type of services you are seeking:

Primary Diagnosis: _____
Other Diagnosis(es): _____

Cognitive Level:
_____ Mild
_____ Moderate
_____ Severe
_____ Profound

Adaptive Level:
_____ Mild
_____ Moderate
_____ Severe
_____ Profound

Cause of intellectual or Developmental Disability*: _____

** Please include a copy of the most recent Psychological Evaluation*

1. Legal Status:

- a. Is the applicant a U.S. Citizen? _____
If not, what is the citizenship status of the applicant? _____
- b. Has the applicant ever been arrested? _____ If so, please give details:

- c. Does the applicant have a court appointed guardian or legal custodian? _____
If so, please complete and attach a copy of the guardianship papers.

Name of Guardian(s) / Legal Custodian(s): _____

Address: _____

Phone: _____

Email: _____

Type of Guardianship: _____

Date of appointment: _____

- d. Has the applicant received services from the Department of Social Services, either from Child/ Adult Protection Services or some other division within DSS? _____
If so, please provide details, including dates of involvement and location:

2. Family Information:

Mother's Full Name: _____ Home Phone: _____
 Home Address: _____ Business Phone: _____
 _____ Cell Phone: _____
 Occupation / Employer: _____
 Email: _____ Date of birth: _____

Father's Full Name: _____ Home Phone: _____
 Home Address: _____ Business Phone: _____
 _____ Cell Phone: _____
 Occupation / Employer: _____
 Email: _____ Date of birth: _____

Please list any other significant people in the applicant's life: (family & non-family, friends, grandparents, etc.):

Name	Relationship	Phone

OTHER IDENTIFYING INFORMATION:

3. Social History:

- a. Where does the applicant currently live: (e.g. at home, with relatives, group home, institution, apartment, etc.)? _____
- b. If living at home with siblings, please list their names and ages:

- c. Marital status of applicant's birth parents (married, divorced, etc.): _____

Applicant Initials: _____

d. Are both parents in agreement of this application? _____ If not, explain: _____

e. How often does applicant see his/her family members? _____

f. List the hobbies, special aptitudes and interests of the applicant. _____

g. Please comment on the applicant's ability to get along with others. _____

h. Behavioral Concerns (check all that apply and explain with details, duration, frequency, etc):

____ verbal aggression *Explain:* _____

____ self injurious *Explain:* _____

____ tantrums *Explain:* _____

____ wandering/running away *Explain:* _____

____ inappropriate sexual behavior *Explain:* _____

____ physical aggression *Explain:* _____

____ property damage *Explain:* _____

____ non-compliance *Explain:* _____

____ self-stimulation *Explain:* _____

____ flopping / dropping weight *Explain:* _____

____ other (_____) *Explain:* _____

Additional comments regarding behavioral concerns: _____

- i. Has a psychiatrist, state hospital, mental retardation center, or mental health center ever treated the applicant for mental health reasons? _____

If yes, please list where and explain circumstances behind the treatment.

4. Education and Employment:

- a. Current day services, school placement, or job:

Name of Program: _____ Phone #: _____

Address: _____

Teacher/Supervisor: _____

- b. Educational history (include name of school, program, address, and dates attended):

- c. Work experience (include employer's name, address, phone number and dates attended):
- _____
- _____
- _____

5. Safety:

- a. How will the applicant respond to a fire alarm? _____
- b. Can the applicant distinguish between a stranger and a friend? _____
- c. Can the applicant distinguish between an emergency, and a non-urgent situation?

- d. Will the applicant be able to dial 911 and convey an emergency situation?

- e. Has the applicant ever engaged in any dangerous activities? _____

Please explain: _____

- f. Are there other safety considerations not already listed in this application? _____

Please explain: _____

- Ø Please describe the type and frequency of supervision needed on a daily basis (e.g. complete supervision, can be alone in room while watching a movie, etc.)?

6. Physical Capabilities, Daily Living Skills, and Support Needs:

Height: _____ Weight: _____

Please check the area that most clearly matches the applicant's current status:

A) Ambulation

- ambulatory
- motorized wheelchair
- manual chair with no assistance
- manual chair with assistance
- walker or cane

B) Hearing

- normal
- impaired
- deaf
- hearing aid

C) Eating Skills

- eats independently
- requires verbal prompt
- requires physical assistance
- requires total assistance *

* Describe: _____

D) Bathing Skills

- independent
- requires verbal prompts
- requires physical assistance
- requires total assistance

E) Dietary Needs

- Diabetic
- requires special diet*
- High blood pressure

*Explain: _____

F) Vision

- normal
- impaired
- blind
- glasses

G) Language

- verbal
- non-verbal
- *adaptive communication

*Specify type: _____

H) Toileting Skills

- independent
- requires verbal prompts
- requires physical assistance
- incontinent

I) Dressing Skills

- independent
- requires verbal prompt
- requires physical assistance
- requires total assistance

J) Overnight Supports / Sleep

- no support required
- some support required *
- extensive support required *

* Explain: _____

Additional Support Considerations, Explanations or Comments:

7. Living Environment:

a. Type of home best suited for applicant:

<input type="checkbox"/> One Level	<input type="checkbox"/> Multi-level	<input type="checkbox"/> Either
<input type="checkbox"/> Same Sex	<input type="checkbox"/> Co-Ed	<input type="checkbox"/> Either

Please Explain: _____

b. What type of peer group would the applicant prefer (i.e. younger, older or same age? Male, female, either? Etc.) Please explain:

8. Medical History:

a. Current medical diagnosis or medical concerns: _____

b. Allergies: Does applicant have any known allergies to drugs/food? Please describe:

c. Seizure History: Does the applicant have a history of seizures? _____

If so, please give: Age of onset: _____

Are Seizures controlled? _____

If not, what type/frequency? _____

d. Does applicant take medication? _____ If so, please identify:

Medication	Dosage	How Often	Reason for Taking

* If prescribed medication, is the applicant able to self-administer medications, or is assistance needed? _____ Describe: _____

e. Describe any past hospitalizations and operations of this applicant:

Month and Year	Type or Reason	Name of Hospital

- f. Please place a check (✓) in front of all of the following tests and immunizations applicant has had and give the last year he/she received them:

(✓)	Year	Test	(✓)	Year	Immunization
		Physical Exam			Tetanus Shot
		Chest X-Ray			DPT
		TB Skin Test			Hepatitis B
		Flu			Polio

- g. Has applicant been screened for Hepatitis B? _____
 If not, screening may be requested upon acceptance into any RSI program.
- h. What is the applicant's response to medical / dental treatment? _____

9. LME / Area Program Affiliation

- a. Is the applicant enrolled at the LME / Area Program?
 Yes ___ No ___ Don't know ___ If yes, list the County: _____
- b. Does the applicant receive any of the following supports? If yes, please list case manager.
- | | |
|--------------------------------|-----------------------|
| ___ CAP MR/DD | Case Manager: _____ |
| | CAP Provider: _____ |
| ___ Community Supports | Case Manager: _____ |
| ___ Developmental Therapy | Case Manager: _____ |
| ___ MR/MI (formerly Thomas S.) | Case Manager: _____ |
| ___ TEACCH | Contact Person: _____ |
| ___ Other: _____ | Contact Person: _____ |

10. Financial Resources of Applicant:

- a. Income Source:
- | | |
|------------------------------|--------------------------|
| Social Security | \$ _____ |
| Social Security Income (SSI) | \$ _____ |
| Earned Income (per month) | \$ _____/mo. From: _____ |

Other: _____ \$ _____

Medicaid Yes ___ No ___
If yes, list: County, State: _____
Contact person: _____

Medicare Yes ___ No ___
Details: _____

CAP-MR/DD Yes ___ No ___ Type / Level: _____
If yes, please list: Hours of CAP per day: _____
Location of service: _____

Other: _____ Yes ___
Private Insurance Yes ___ No ___
If yes, please list: Name of insurance company: _____
Type of insurance: _____
Subscriber name: _____
Relationship to the applicant: _____

b. Assets:

Does the applicant have any assets? Please check all that apply:

- Bank account(s): Yes ___ No ___ If yes, type: _____
- Real Estate: Yes ___ No ___
- Stocks: Yes ___ No ___
- Cash: Yes ___ No ___
- Trust(s): Yes ___ No ___
- Burial Plot: Yes ___ No ___
- Life Insurance: Yes ___ No ___
- Other: Yes ___ No ___ Details: _____
- Other: Yes ___ No ___ Details: _____

I certify that all pertinent information in the areas of behavioral problems, sexual problems, physical capabilities, psychological difficulties, and any incidents which may have occurred in these areas have been given to the Admissions Committee of **Residential Services, Inc.** No information has been withheld.

I hereby apply for admission to a program operated by **Residential Services, Inc.** I agree to abide by the rules and regulations of the program, and understand that violations of the rules can result in discharge from the program.

Date Signature of Applicant (*Required if own guardian*)

Date Signature of Parent or Guardian (*Required*)

Signature of Parent or Guardian (*Required if Co-Guardianship*)

Date Signature of Person Completing Application

Relationship to Applicant

Address

Phone

***** Person to notify upon receipt of this application:** _____

Residential Services, Inc., complies with the requirements of the Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

By law, we are required to protect the privacy of the medical information and other personal information that we receive or create regarding our participants or applicants. The attached HIPAA policy authorizes our responsibilities and procedures.

