Thank you for your interest in Benedictine Adult Services. Please complete the application in its entirety. In addition to the application, all applicants need to submit the following information in order for the Admissions Committee to review and make a decision on acceptance:

- Copy of identification card
- Copy of Social Security card
- Certified copy of birth certificate
- Medical and social histories

The following information needed must be current (within a year from application submittal):

- Recent annual planning document (IEP/IP/Person-Centered Plan)
- Psychological and/or psychiatric evaluation (within a year of)
- Physical
- Dental exam records

Finally, the following information is requested but may not be applicable to every applicant:

- Residential records
- Vocational/employment records
- DORS and/or vocational evaluation
- Current or past behavior plan
- Copies of Legal Documents / Guardianship

If you have any questions regarding our criteria and procedures, please see the Admission Policy for in depth information. Please understand that until all of the above information is received, the application will not be reviewed. It is the applicant's responsibility to submit all required information to the Admissions Committee. Please note that applications and information will only be accepted if the application was completed no more than one year prior to the requested start date.

Benedictine Adult Services
14299 Benedictine Lane * Ridgely, Maryland 21660
Phone: 410.634.1990
ocpadultadmissions@benschool.org

Please attach a recent picture of applicant here.

Check Program(s) for which application is submitted:

☐ Residential ☐ Supported Employment ☐ Vocational/Day Habilitation ☐ Personal Supports

Anticipated Start Date:___________________________

A. Applicant's General Information

Name of Applicant:____

Address:____

(Street) (City) (State) (Zip)

Phone:___________________________ Social Security #:_____________________________________

Date of Birth:_______________________Birthplace:_______________ Gender: ☐ female ☐ male

Legal Guardian Name (if applicable):____

____

(Street) (City) (State) (Zip)

Phone: (Home)____________________(Cell)_____________________(Work)___________________________

Does the Applicant have a Maryland Coordinator of Community Supports/Service Coordinator?

____

(Name)

____

(County, State) (Phone) (Fax)

What does the individual do during the day?

Employment/School/Day Program:____

____

(Street) (City) (State) (Zip)

Contact Person:_________________________________Phone:_______________________________________

Please list any other Providers/Agencies involved:

Name of Program	Contact Person	Phone

B. Family Information

Father (or guardian)

Name: ____________________

Address: ____________________

____
(County) (City)

____
(State) (Zip)

Date of Birth: ____________________

Occupation: ____________________

Phone: (Home) ____________________

(Cell) ____________________

(Work) ____________________

Email: ____________________

Mother (or guardian)

Name: ____________________

Address: ____________________

____
(County) (City)

____
(State) (Zip)

Date of Birth: ____________________

Occupation: ____________________

Phone: (Home) ____________________

(Cell) ____________________

(Work) ____________________

Email: ____________________

Name of person to be notified in an emergency (other than either of the above):

Name: ____________________ Relationship: ____________________

Phone: (Home) ____________________ (Cell) ____________________ (Work) ____________________

Does the individual have any siblings?

Name	Age

C. Funding

Does the person have funding for services: ☐ Yes ☐ No, why: ____________________

____

If yes, funding type:

☐ Adult Medical Day ☐ FPS – Day

☐ TBI Waiver – Day
☐ TBI Waiver – Residential
☐ FPS – Residential
☐ Other:____

D. Specific Applicant Information

1. Communication *(Check any which are appropriate and explain, if necessary)*

☐ communicates in sentences
☐ uses sign languages
☐ uses some words
☐ does not understand commands
☐ uses flash cards/picture books
☐ uses a communication device
☐ does not use words
☐ understands some/most commands

Comments:____

2. Eating Habits *(Check any which are appropriate and explain, if necessary)*

☐ independent
☐ dependent
☐ needs pureed food
☐ has history of choking
☐ assistance with preparation
☐ needs assistance eating
☐ uses feeding tube
☐ has choking protocol

Comments:____

3. Bathing/Hygiene

Assistance in/out of tub:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance with bath/shower:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance shaving:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Menstrual needs:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance dressing:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance tooth brushing:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance with hair care:	☐ independent	☐ supervised	☐ dependent	☐ N/A

Comments:____

4. Toileting *(Check any which are appropriate and explain, if necessary)*

☐ continent
☐ sometimes incontinent
☐ stress incontinent
☐ uses Depends at night only
☐ frequent UTI
☐ toilets independently
☐ always incontinent
☐ night time incontinent
☐ uses Depends during day and night
☐ has doctor’s order for use of Depends
☐ has Urinary/Foley catheter
☐ requires assistance with toileting

Comments:____

____

5. Sleep Habits

Does individual have a usual bedtime? ☐ Yes ☐ No What time?______________________

Does individual take a nap? ☐ Yes ☐ No What time?______________________

Does individual use breathing device: ☐ Yes ☐ No

If yes, what type of device:____

Does individual wake up during the night? ☐ Yes ☐ No

If so, what should be done?____

Comments:____

____

6. Mobility *(Check any which are appropriate and explain, if necessary)*

- ☐ walks independently
- ☐ wheelchair used sometimes
- ☐ able to transfer from wheelchair to chair
- ☐ uses a walker
- ☐ walks, but needs assistance
- ☐ wheelchair used all the time
- ☐ uses cane/crutches
- ☐ able to climb stairs

Comments:____

____

E. <u>Personal Information</u>

Please list any hobbies:

____

____

____

Is the individual social? What social activities are of interest?

____

____

____

Does the individual attend regular religious services? (Please list name and address)

____

____

____

Does the individual have favorite TV shows or movies?

____

____

____

Does the individual do any chores (vacuuming, setting table, taking trash out…) in the home?

____

____

____

Does the individual have any fears Benedictine should be aware of?

____

____

Please describe the individual's personality traits:

Does the individual like/dislike any animals?

Describe the ability of the individual to cope with change in daily routine?

Does the individual read and write?

Is the individual able to remain home unsupervised? How long? Any restrictions/considerations?

Does the individual have any behaviors that have been of concern?

Does the individual have a formal behavior plan?
☐ Yes ☐ No Developed by:____________________

Has the individual ever been convicted of a crime? ☐ Yes ☐ No
If yes, please explain:____________________

F. Medical and Health Information

1. Diagnosis

2. Any Allergies (medications or environmental):____________________

3. Height: ____________________ Current Weight:____________lbs.__________

4. Immunizations:

Hepatitis B Vaccine: ☐ Yes ☐ No Date: ______________

Hepatitis B Carrier:	☐ Yes	☐ No	☐ Unknown		
PPD (TB test):	☐ Yes	☐ No	Date: ______________	☐ Positive	☐ Negative
MRSA Carrier:	☐ Yes	☐ No			
Tetanus:	☐ Yes	☐ No	Date: ______________		
Measles, Mumps, Rubella:	☐ Yes	☐ No	Date: ______________		
Flu Shot:	☐ Yes	☐ No	Date: ______________		
Pneumonia vaccine:	☐ Yes	☐ No	Date: ______________		

Does Applicant have a contagious condition? ☐ Yes ☐ No
If yes, explain:____

5. Does the individual need assistance with taking medication?

☐ Yes, complete assistance ☐ Needs prompting to take ☐ Self Administrating

6. How does the individual take their medication?

☐ Takes medication without difficulty (give with 8 ounces of fluid/water)
☐ Crushed pills/tablets
☐ Takes with applesauce or other soft food item
☐ Liquid form of medication
☐ Liquid form with thick it
☐ G-tube only, nothing by mouth
☐ Other:____

7. Has the individual ever had a choking incident? ☐ Yes ☐ No

8. Has the individual ever had pneumonia? ☐ Yes ☐ No Date:______________

9. List any adaptive equipment and specify time when used (helmet, eating utensils, splint, AFO...)

Adaptive Equipment *Example: Splint on right hand*	Time Adaptive Equipment is used *Example: at bed time during sleep hours*
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

10. Seizures

Does individual experience seizures? ☐ Yes ☐ No
Do seizures last longer than 5 minutes? ☐ Yes ☐ No How long:__________mins.________
Frequency? ☐ daily ☐ weekly ☐ monthly ☐ other:______________________

Describe Seizures: *(Example: unresponsive, one side of arm or leg jerks, drooling, bluish facial color, will tell you has funny feeling in head, sleeps after seizures for 30-45 minutes, incontinent…)*

____
____
____

How long after their seizure do they sleep?______________________________

During/after seizure are there any special procedure/medications to be given?___________________________
____
____

11. Last Physical:_________________Findings/Concerns:_______________________________________
____

12. Physicians/Health Care Provider *(Please skip if you are not applying for Residential Services)*

Primary Physician (PCP):__________________________________Phone: _________________________

____
(Street) (City) (State) (Zip)

Date of last visit:_________________ Reason:____

Dentist:_____________________________________Phone: _____________________________________

____
(Street) (City) (State) (Zip)

Date of last visit:_________________ Reason:____

Psychiatrist:_________________________________Phone: _____________________________________

____
(Street) (City) (State) (Zip)

Date of last visit:_________________ Reason:____

Psychologist:________________________________Phone: _____________________________________

____
(Street) (City) (State) (Zip)

Date of last visit:_________________ Reason:____

Specialist:___________________________________Phone: _____________________________________

____
(Street) (City) (State) (Zip)

Date of last visit:_________________ Reason:____

Specialist:___________________________________Phone: _____________________________________

____
(Street) (City) (State) (Zip)

Date of last visit:_________________ Reason:____

Specialist:___________________________________Phone: _____________________________________

____
(Street) (City) (State) (Zip)

Date of last visit:__________________ Reason:____

Hospital familiar with individual:____

13. Medication List:

Name	Dose	Frequency	Route
EXAMPLE MEDICATION	100mg	3x per day	By mouth
Name	**Dose**	**Frequency**	**Route**

14. General Health *(Please check all that apply):*

☐ Impaired ability to carry out activities of daily living
☐ Sleeps during the night time hours
☐ Has difficulty sleeping or falling asleep during night time hours
☐ Do they nap/sleep during the day time hours? Times:______________________________________
☐ Any presence of old scars, bumps or lumps? Specify:_____________________________________
☐ History of sinus infections
☐ History of nose bleeds
☐ Difficulty chewing or swallowing
☐ Date of last dental exam: ___________________________
☐ Use of dentures or bridges
☐ Overall description of teeth (scattered teeth, missing, no teeth) _________________________________
☐ History of eye problems
☐ Use of corrective lens (glasses) Rt. __________ Lt. ______________
☐ History of cataracts or glaucoma ☐ Cataracts removed Date:_________________
☐ Abnormal sensitivity to noise or touch
☐ History of ear infections
☐ Legally blind
☐ Uses a hearing aid Rt. ________ Lt. ________
☐ History of pneumonia or bronchitis
☐ Difficulty breathing (wheezing, asthma, or other breathing problems)
☐ Needs to sit up to breathe, especially at night
☐ Swelling of ankles or feet or other areas of the body ____
☐ Discoloration of fingers, toes or other parts of the body ____
☐ History of stomach ulcers, vomiting blood
☐ History of refluxing, pain upon eating or nausea
☐ History of constipation

☐ History of diarrhea
☐ Changes in bowel elimination pattern
☐ History of hemorrhoids
☐ Use of laxatives, stool softeners
☐ Use of high fiber diet or prune juice or other natural fiber
☐ Uses toilet schedule for urination/BMs Specify:_______________
☐ History if urinary tract infections
☐ Does the individual smoke/drink alcohol? Specify:_______________
☐ History of fainting or loss of consciousness
☐ History of nervous system problem
☐ History of cognitive disturbances, including recent or remote memory loss, hallucinations, disorientation or inability to concentrate
☐ History of speech and language dysfunction
☐ History of motor problems, including problems with gait (walking), balance, tremors or spasm paralysis
☐ Interference by cognitive, sensory, or motor symptoms with ADLs
☐ History of fractures Specify:_______________
☐ History of joint deformities or contractures
☐ Spinal deformity
☐ Chronic back problems (spinal rods)
☐ History of anemia
☐ History of easy bruising
☐ History of thyroid problems, adrenal problems, diabetes
☐ Any open sores, wounds or rashes on body area Specify:_______________
☐ Heat or cold intolerance
☐ Increases thirst
☐ Unexplained changes in weight (increase or decrease)
☐ PAP for female older than 40 years
☐ History of mental illness (bipolar, OCD…) Specify:_______________

15. Medical Insurance/Policy Numbers:_______________

____

16. Any additional medical/health information/concerns:_______________

____

17. Does the individual have an advanced directive? ☐ Yes ☐ No

G. Educational/Vocational Data

1. Schools Attended

School/Address	Year	Grade Accomplished

2. Other Programs Attended

Facility/Address	Year	Grade Accomplished

3. Job Training, Volunteer, and/or Employment

Job Training/Place of Employment	Position	Date	Reason Left

4. Present Job Placement:______________________________

Hours per week:______hrs.__________ Earning per hour/week/month: __$__________per__________

H. Transportation

For Vocational Services only:

Does Individual have reliable transportation for employment purposes? ☐ Yes ☐ No

Has Individual utilized any type of public transportation? ☐ Yes ☐ No

If yes, please indicate which public transportation service was used: ______________________________

____

____

Does Individual require any special accommodations for transportation (ex. wheelchair accessible)?

☐ Yes ☐ No If yes, please indicate______________________________

____

____

I. Representative Payee Information *(Please skip if you are not applying for Residential Services)*

Name of Rep Payee:______________________________Phone:____________________

____

(Street) (City) (State) (Zip)

I elect Benedictine Adult Services to become Rep Payee: ☐ Yes ☐ No

J. Other Benefits Information *(Please skip if you are not applying for Residential Services)*

Does the individual receive Food Stamps? ☐ Yes ☐ No

If yes, what County? ______________________________Food Stamp ID#:____________________

SSI Claim Number:______________________________SSI Amount:_$____________________

SSA Claim Number:______________________________SSA Amount:_$____________________

SSDI Claim Number:_________________________________SSDI Amount: $________________________

Does individual have a burial plan?____

Burial Plot Location:_________________________________Estimated Value: $______________________

Life Insurance Coverage:____

Does the individual have a trust fund? ☐ Yes ☐ No

If yes, type:____

Name of Rep Trustee:______________________________________Phone:__________________________

____

(Street) (City) (State) (Zip)

Does individual have a Bank Account? ☐ Yes ☐ No Bank Name:____________________

I understand that the application information is for the purpose of assisting Benedictine Adult Services in serving me now and/or planning with me for the future. I understand that all information will be treated in a strictly confidential manner.

____ __________________________

Signature of Applicant (if at least 18 years old) or guardian Date

____ __________________________

Signature of Person Completing Application Date

Benedictine Adult Services places no restrictions as to the applicant's race, color, creed, national origin, political affiliation, marital status, age, sex, sexual orientation or disability. Benedictine is an Equal Opportunity Service Provider.