Focus Forward™

Application

General Information

Applicant's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Parent/Guardian Names

Guardian 1: _____ Cell Phone: _____

Email: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Guardian 2: _____ Cell Phone: _____

Email: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Client lives with: ☐ Both guardians ☐ Guardian 1 ☐ Guardian 2 ☐ Other Please name: _____

Guardianship: ☐ No ☐ Yes Please attach documentation. ☐ Other Please name: _____

Physician/Therapist Information

Physician Name: _____ Phone: _____

Therapist Name: _____ Phone: _____

Seizure Information

Do you have seizures? ☐ No ☐ Yes How long do seizures last? _____

Please describe the seizures: _____

Date of last seizure: _____

Seizure response plan: _____

Allergy Information

Medication Allergies: _____

Food Allergies: _____

Other Allergies: _____

Latex Allergies/Sensitivity: ☐ No ☐ Yes

Special Diet/Dietary Needs: _____

Medications: _____

Please list all medications you take, including dosages and times: _____

Can you administer medications for yourself while at Focus Forward? ☐ No ☐ Yes

Please list and describe any other medial conditions: _____

Communication

Communicates Independently ☐Yes ☐No

Verbalizes ☐Yes ☐No

Gestures ☐Yes ☐No

Sign Language ☐Yes ☐No

Has hearing loss ☐Yes ☐No

Wears hearing aid ☐Yes ☐No

Writes Independently ☐Yes ☐No

Other Information: _____

Eating

Manages food/drinks independently ☐Yes ☐Minimal support ☐No

Other Information: _____

Personal Hygiene/Toileting

Independent toileting/ hygiene care ☐Yes ☐Minimal support ☐No

Other Information: _____

Have you ever received special behavioral treatment or therapy, such as wrap-around services, or ABA (Applied Behavioral Analysis)?

☐ No ☐ Yes If yes, provide dates: _____

Where were the services received? Please provide name/address.

Describe any self-stimulatory behaviors and/or aggressive behaviors, such as rocking, head-banging, and/or verbal, physical aggression, fixation or tics, etc.

Describe any significant behavior issues, e.g. running away, stealing, obsessions and/or compulsions, destructiveness, self-abusive, aggression (verbally/physically toward self, younger/vulnerable population, or animals, etc.)?

When do(es) the inappropriate behavior(s) usually occur? What conditions/situations might trigger these behaviors?

What do you do to address the negative behaviors?

How do you respond to redirection?

Have you had a formal "behavior plan (PBSP)" in the past? If so, are you willing to work with the staff to review and modify if necessary?

Describe any issues or history of difficulties around sexuality. Are you open to working with the program staff in this area?

Do you have any emotional difficulties? Please explain.

Do you require assistance and/or adaptive equipment for mobility (i.e. walker, braces, wheelchair, etc.)?

Have you ever been treated by a psychologist, psychiatrist, counselor, or other mental health professional? If so, why?

Approximate dates seen:

Recommendations given

Additional comments

What activities/sports do you enjoy?

Describe your strengths and talents:

Attendance Days/Times: ☐M ☐T ☐W ☐Th ☐F ☐Morning (9 a.m. - 12 p.m.) ☐Afternoon)12 - 3 p.m.)

Requested Start Date:

I hereby represent that the above information provided by me is accurate to the best of my knowledge.

Applicant Name:

Applicant Signature: Date:

Parent/Guardian Name: Date:

Parent/Guardian Signature:

Payment Method: ☐ Medicaid Waiver ☐ Private Pay (email for rates)

Medicaid Waiver Information

Focus Forward is an approved Medicaid Waiver Provider for ADT (Adult Day Training). Please supply the following information:

MedWaiver Client Name:

Support Coordinator Name:

Name & Address of Agency:

Agency Phone Number:

If accepted into our ADT program, your support coordinator must submit proof of approval in the form of a service authorization for "Adult Day Training." We will also need to receive a copy of your support plan indicating the goals you have chosen to work on while attending Focus Forward.

Client Goals/Expectations

Focus Forward is a person-centered program, so knowing what you want to achieve here and the goals you have set is essential to your success. Please list any and all goals YOU would like to work on at Focus Forward. (Please include goals listed on the your support plan as well as any other goals you feel are important to you.)

Background Information

Are you currently employed?

If so, what hours/days?

Have you been to an ADT before (or similar program)?

If so, what hours/days?

What high school did you attend?

How did you hear about us?