ABILITY CENTER OF VIRGINIA
ABILITY DAYS/ARTS WORKS
APPLICATION FORM FOR ADMISSION

Participant Information:

Name_____ Date _____

Date of Birth_____ Age_____

Height_____ Weight_____

Address_____
City State Zip

Home/Cell Phone_____ Email Address_____

What is your disability?_____

Do you live on your own? ___ If no, do you ever want to live on your own?
_____

Do you schedule your own transportation to go out into the community?
_____

Education/Employment History:

Are you currently employed?_____

If yes, where and how many hours do you work per week?_____

_____

If no, do you want to get a job? _____

What is your current salary?_____

What school did you attend?_____

What grade did you complete?_____

What is you level of reading?_____

What is you level of math comprehension?_____

What type of diploma did you receive?

Regular_____Special Education_____

Emergency Information:

Your emergency information is extremely important. Please fill out completely.

Who should we contact first in case of an emergency:

Name_____ Relationship_____

Home phone_____ Cell phone_____Work phone_____

Who should we contact if we are unable to reach your first contact in case of an emergency:

Name_____ Relationship_____

Home phone_____ Cell phone_____ Work phone_____

Medical Information:

This is important information that needs to be filled out completely.

Physician's name_____

Physician's address_____
City State Zip

Physician's phone number_____

Name of primary insurance carrier_____

Primary medical diagnosis_____

Secondary medical diagnosis_____

Please list all medication you currently take (include dosages and reasons for taking):

_____

_____

_____

Please list any environmental or food allergies:

_____

_____

Are you on a special diet?
_____

Are there any foods that you cannot or will not eat?
_____

What is your favorite food?
_____

Do you have seizures? _____Yes _____No If yes, please describe the characteristics:

_____

Do you smoke? _____Yes _____No If yes, how many cigarettes do you smoke per day?

_____

Do you drink? _____ Yes _____ No If yes, how much and how often?_____

_____

Do you have any physical limitations? ____Yes ____ No If yes, please list_____

_____

_____

Please describe any visual impairments you may have_____

_____

Please describe any hearing impairments you may have_____

_____

Please describe any speech impairment you may have_____

_____

Do you have any inappropriate behavior problems?_____Yes _____ No If yes, please describe in detail_____

_____

_____

Have you ever been denied participation in any programs due to aggressive behavior problems? ____Yes _____No If yes, please describe in detail_____

_____

_____

Do you receive psychological counseling? _____ Yes _____ No If yes, what is the name of your current counselor_____

What is their address_____
City State Zip

Phone number_____

Are you on medication for depression or behavioral issues? _____ Yes _____ No

If yes, please list what kind and the dosage_____

_____

Expressive/Receptive Information:

What is your primary means of communication?

_____Speech	_____Vocalization	_____Manual signing
_____Bodily gestures	_____Facial expressions	_____Eye pointing
_____Spoken "Yes-No"	_____Gestural "Yes-No"	_____Communication device

Please indicate if your speech is one of the following:

_____Understood by family/friends and strangers
_____Understood by family and close associates only
_____Difficult for family and close associates to understand
_____Never understood by others

What best describes you when you are not understood:

_____Persistent	_____Quickly discouraged
_____Frustrated	_____Apathetic
_____ Angry	

Do you have any difficulty understanding other's speech?_____Yes _____No

If yes, please explain_____

Do you initiate communication with others?_____Yes _____No Please explain_____

_____

Do you use a communication device?____Yes _____No If yes, please list the type

of equipment used_____

What best describes your nutritional habits _____good _____fair _____poor

How would you describe your overall health_____

_____

Please describe your method of mobility:

_____Walk unassisted _____Walk with some assistance _____Use crutches
_____Wear braces _____Use wheelchair_____Manual or _____ Motorized

How old is your wheelchair?_____ Do you walk with little

assistance but use wheelchair when out for long periods of time? ____ Yes _____ No

Do you have good balance?_____ Yes _____ No If no, please explain_____

_____

Do you have any of the following (please check all that apply)?

_____Scissoring _____Crouched gait_____Loss of balance

Upper extremity contractures, where_____

Lower extremity contractures, where_____

_____Incontinence _____Seizures

Skin breakdown, where_____

Loss of sensation, where_____

Allergies to medication, what_____

Any other medical or emotional problems we should be aware of_____

_____

Activities of Daily Living:

_____Feed self _____Toilet self _____Administer own meds
_____ Cook own food

If no in any of the above areas, please explain why and how this function is performed

for you_____

_____

Do you have difficulty chewing or swallowing? _____Yes _____ No

If yes, please provide details_____
_____

Do you have full range of motion? Left hand_____ Right hand_____

Can you grasp and pick up objects? Left hand_____ Right hand _____

Please describe your manual dexterity_____

_____

Do you wear glasses? _____ Hearing aids? _____

Please describe any other adaptive or communication equipment you currently use_
_____

_____

Do you have an aide? _____Yes _____No_____ If yes, will your aide be accompanying you to
the program?_____

Do you receive services from your local Community Services Board? _____Yes
_____No

If yes, please provide the name of your case worker, their phone number, the city you receive services from as well as an address_____

_____

Social Interaction Information

Do you participate in any social groups outside of Adult Day? If yes, what are they?

_____

What are your favorite social activities?_____

_____

Who are the significant people in your life?_____

_____

Do you have any hobbies or collect any items of interest? If so, what_____

_____

Do you get along with others?_____ Yes _____No If no, please explain _____

_____

What do you do for
fun?_____

What are your recreational goals?
_____

Financial Information

Do you receive Social Security Income? _____ Yes _____ No If yes, what is your monthly benefit check? $_____

Do you receive income from a job? _____ Yes _____ No If yes, what are your weekly gross earnings? $_____

Do you receive income from a trust or your family? _____ Yes _____ No If yes, what is the monthly amount received? $_____

Please provide us with a copy of your most current W2 tax form.

Ability Center of Virginia
Ability Days Program
Consent Form

Name: _____

No participants can be accepted for the Ability Center of Virginia Adult Day Social & Recreation Program until this form has been completed by the parent(s) and/or guardian(s). If the participant is of legal age (18), he or she may complete the form if he or she is legally competent to do so. Program instruction will be under strict supervision and, although every effort will be made to avoid any incident, **NO LIABILITY can be accepted by Ability Center of Virginia.**

Physician's Name: _____

Office Address: _____

City: _____State: _____ Zip: _____Phone: _____

I would like _____ to participate in Ability Center of Virginia's Ability Days Program and I have discussed this with the participant's doctor. I understand that **NO LIABILITY** will be placed on Ability Center of Virginia for injury of any kind to _____ in the event of any accident occurring.

Signature of participant 18 and over _____

Date: _____

Signature of parent(s) and/or guardian(s) _____

Date: _____

We would appreciate any further information about the participant that you as a parent/guardian think would be helpful such as fears of any kind, past injuries, PT and OT reports or other recommendations.

ABILITY CENTER OF VIRGINIA
PHOTO RELEASE CONSENT FORM

For valuable consideration given in which is hereby acknowledged, the undersigning hereby grants to **ABILITY CENTER OF VIRGINIA** permission to take or have taken still and moving pictures of our/my (daughter-son-ward) _____ and consents and authorizes **ABILITY CENTER OF VIRGINIA,** its advertising agencies, news media and any other persons interested in **ABILITY CENTER OF VIRGINIA** and its work, to use and reproduce the pictures and films and to circulate and publicize the same by all means including without limiting the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional material books, and clinical material. With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of **ABILITY CENTER OF VIRGINIA** to use or cause to be used such pictures and films for the primary purpose of promoting and aiding **ABILITY CENTER OF VIRGINIA** and its work.

Date: _____

Signature of parent(s)/guardian(s): _____

_____

Please note that this photo release form will be valid for one year from date signed.

Ability Center of Virginia
Ability Days Program
Field Trip Permission For Field Trip Transportation and Supervision:

Transportation will be provided for Ability Center's Ability Days Program participants to and from the field trip destination by the staff of Ability Center of Virginia. Participants will be directly supervised throughout the excursion by Ability Center staff and /or volunteers.

Agreement

Signature of participant or parent/guardian: _____

Date: _____

Please contact the following in case of an emergency:

Emergency contact name: _____

Phone number: _____ Cell: _____

ABILITY CENTER OF VIRGINIA
ADULT DAY PROGRAM
PHYSICIAN CONSENT FORM

This form is to be completed by your personal physician and returned with your application for the Ability Center of Virginia Ability Days Program. Your participation in the program will not be accepted until this form is completed and returned to Ability Center of Virginia. Thank you for your help and cooperation in this matter.

Participant name: _____

Address: _____
City State Zip

Phone: _____

Date of birth: _____

Primary diagnosis: _____

Date of diagnosis: _____

Medical history pertinent to the primary diagnosis: _____

_____

_____

Secondary diagnosis: _____

_____

_____

Does the patient have any history of psychological, emotional or behavioral problems? _____ If so, please explain: _____

_____

_____

Please provide a list of all medication the patient is currently taking, the daily dosage and the medical diagnosis the medicine is prescribed for: _____

_____

Is the patient currently receiving counseling for any emotional disorders? _____

If so, please explain: _____

Please list any surgical procedures the patient has had: _____

Please provide any information regarding any of the below listed impairments the patient may have:

Visual impairments: _____
Auditory impairments: _____
Speech impairments: _____
Physical mobility limitations: _____

In my opinion, this patient will benefit from the Adult Day & Social Recreation Program.

Physician's name: _____

Address: _____
City State Zip

Phone: _____ Fax: _____

Email address: _____

Physician's signature: _____

Date: _____