St. Coletta of Greater Washington, Inc
5301 Marinelli Rd.
Rockville, MD 20852
301-804-4360
Fax: 301-804-4370

ADMISSION APPLICATION FOR ADULT PROGRAM

Instructions: Please submit this completed application along with a recent psychological evaluation, medical evaluation, current service plan and any other relevant reports to the Director of Adults Services at the address above.

DATE: ____________________

CONSUMER INFORMATION

Consumer's Name: LAST___________________ FIRST_____________________ M.____________

Address: ____ Phone #: (______)_________________

City: _______________________ State ________________ Zip ______________________________

Date of Birth: ________________Gender: Male or Female (circle one) SSN: __________________

Does the applicant receive Medical Assistance? ________ Yes ________ No

Medicaid #:____________________________

Health Insurance Carrier/Primary Physician____

Is English the primary language spoken at home? ________ Yes ________ No If no what is the

Primary language at home____

High School: ____________________________ TST: ____________________________________

Anticipated Exit Date: ____________________________ Diploma or Certificate? (Circle One)

Please circle all services currently receiving or applied for: DDA DORS HOC Medical Assistance

SSI SSDI Metro/Ride- On Para Transit Metro Access Call N Ride Other:_____________________

NAME________________ DATE_____________

Have you ever been charged or convicted of a crime? Yes or No (circle one)

Are you on probation or parole? Yes or No (circle one)

If Yes, what is your status?

____
____

Have you ever been found legally incompetent? Yes or No (circle one)

If Yes, please explain

____
____
____

Are you currently receiving day or vocational services? Yes or No (Circle one)

If Yes, what is the name of the program? ____

If Yes, why are you seeking a change?

____
____
____

Reason for Seeking Admission:

____

Please indicate current diagnoses:

____
____

Please list any devices utilized for mobility, vision, speech, etc:

____
____

Please not other physical or medical considerations (tracheotomy, g-tube, insulin pump, etc):

____
____

Will medication be taken during program hours? Yes or No (Circle one)

Please indicate any current professional services (Speech Therapist, Neurologist, Psychologist, etc) and name of practitioner:

____
____
____

Brief Medical History:

____
____
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____

(Please Comment on Consumers)

Self-Direction:

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____

Special Skills & *Talents:*

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____

Communication Skills & Preferred Mode of Communication:

____

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____

Interpersonal Skills:

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Mobility:

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Self-Care:

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____

Likes & Dislikes:

____
____
____
____

COMMENTS/ADDITIONAL INFORMATION:

____
____
____

Check all that apply: ____ **PARENT and/or** ____ **LEGAL GUARDIAN** INFORMATION:

Relationship to Consumer:____

Name: ____

Home Address: ____

Phone Number: ____

Email Address: ____

Father/Guardian Employer ____

Name/Address/Telephone ____

____

Mother/Guardian Employer____

Name/Address/Telephone ____

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SIBLINGS NAME AGE GENDER

____

____

____

Religious Preference (Optional):____

Service Coordinator INFORMATION:

Name & Title:____

Address:____

City:____________________ State:_____________ Zip Code:_________________________

Phone #: __(____)______________________________

FAX #: ___(_____)______________________________

Signature of Consumer____ Date _____________________

Signature of Parent and/or Legal Guardian:_________________________Date_______________

FOR ADMINSTRATIVE USE ONLY

Accepted/Denied/Waiting List ____

Reason: ____

____

Date of Admission to the Program: ________________

Date Services Initiated: _________________________

____ ____________________

St. Coletta Executive Director's Signature **Date**

Revised /11