St. Coletta of Greater Washington
Adult Services Division, Rockville

Seeing possibilities beyond disabilities

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 Adult 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_______________

5301 Marinelli Road, Rockville, MD 20852
Tel: (301) 804-4360 ■ Fax: (301) 804-4370
www.stcoletta.org

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 ____

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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?

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Reason for Seeking Admission:

____

Please indicate current diagnoses:

____

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

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Please note other physical or medical considerations (tracheotomy, g-tube, insulin pump, etc.):

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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:

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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:

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COMMENTS/ADDITIONAL INFORMATION:

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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 ____

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Mother/Guardian Employer____

Name/Address/Telephone ____

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SIBLINGS NAME AGE GENDER

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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 /2018