Applicant Name:_____

For office use only		***Name of Location***	
Date of Enrollment		***Date of Admission***	
Date of Discharge		***Reason***	

Admissions Application

Please complete all blanks on this application. Completed the application does not ensure enrollment but is necessary for processing. **Attach the following and send with your completed application to Eighth Street Community, 305 8th Street, Huntsville, Alabama 35805:**

- **Recent Photograph and non-drivers state identification**
- **Copy of birth certificate**
- **Completed Medical Examination Form**
- **Recent Psychological Evaluation**
- **Social Security Summary**

Applicant Name: _____
Last First Middle

Current Address: _____
Street City State Zip Code County

Mailing Address: _____
(If different from above) Street City State Zip Code County

Telephone # **Social Security #** _____

Referred by: _____
Name Relationship to Applicant Application Date

DESCRIPTION OF INDIVIDUAL

Date of Birth _ **Place of Birth** ____
Religious Preference _____ **Citizenship** ____
Marital Status _ **Has Referral been declared Legally Competent** _
Sex _____ **Race** _____ **Eye Color** _____ **Hair Color** _____ **Height** _____ **Weight** _____
Identifying Marks _____
Language Spoken: _____

CURRENT DAY PROGRAMS / ACTIVITIES / TREATMENT

Current Employment/Day Program / School: _____
Name

Address **Telephone** **Supervisor**

Include program name, assignments, job descriptions, accomplishments, earnings, and /or training. **Please mark an X to activities in which transportation is provided.**

Day of Week	Description	X
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Applicant Name:_____

Is the applicant able to work, but not working? List past experience or reasons why individual would be capable.

APPLICANT'S FINANCIAL INFORMATION
***Additional sources of income needs to be filed on the Financial Assistance Document**

INCOME:

Source Amount	$ Per Month	Payee

ADDITIONAL ASSETS (Trust Funds, 401(k), Savings, etc.):

Type	Amount / Value

INSURANCE

Insurance Type	Name of Company	Name of Policy Holder	Policy Number
Health / Medical (1)			
Health / Medical (2)			
Life			
Burial			
Other			

EMERGENCY CONTACT

Responsible Person / Legal Guardian: Last First Middle

Home Address: Street City State Zip Telephone

Business Name/Address: Street City State Zip Telephone

Other Emergency Contact: Relationship Name Telephone

Other Emergency Contact: Relationship Name Telephone

REFERRALS

Sponsor Name (or where is patient coming from): _____
How did you find out about our facility: _____

Applicant Name:_____

List Social Service Agencies, Hospitals, or Physician's where the patient may have received special treatment in the past:

Name of Agency	Reason for Services / Referral	Date Services Received

ADDITIONAL COMMENTS:

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

AGE AT WHICH INDIVIDUAL FIRST:

Held up head	_____	**Crawled**	_____	**Used words clearly**	_____
Sat alone	_____	**Stood alone**	_____	**Walked alone**	_____

TOILETING

Toilet trained	_____	**Wets pants**	_____	**Soils pants**	_____
Soils bed	_____	**Goes sometimes**	_____	**Goes when taken**	_____
		Indicates need	_____	**Uses Diapers**	_____

FEEDING

Adequate table manners	_____	**Uses a knife**	_____
Feeds self with fork	_____	**Drinks from a glass**	_____
Feeds self with spoon	_____	**Uses hands to eat**	_____

SELF-HYGIENE ABILITIES AND SKILLS

Is the Applicant Able to:	Yes	No
Shower or take a bath alone		
Brush Teeth		
Shave Self		
Comb Hair		
Answers Phone		
Determine common dangers		
Dress themselves		

BEHAVORIAL HEALTH HISTORY (YES or NO)

Interacts with Peers _____ **Good** _____ **Fair** _____ **Poor**
If poor, list specific problem areas: _____

_____

Physically Aggressive	_____	**Destroys Property**	_____
Abuses Self	_____	**Masturbates Openly**	_____
Temper Tantrums	_____	**Sexually Active**	_____
Drug Abuse	_____	**Alcohol Abuse**	_____
Addiction (or OCD Behavior)	_____	**Mental Health Court**	_____

Applicant Name:_____

Other Behavioral Problems (EXAMPLE: initial response to "no" or "you can't do that"; response to schedule change)

Criminal Status: Please indicate any contacts with Law Enforcement / Indicate if case is Pending (This includes any interaction with Law Enforcement; calls made on the individual's behalf, etc.) :

Recreational Interest (EXAMPLES: enjoys cross word puzzles, knits, plays music, collects things, etc):

MEDICAL INFORMATION

DIAGNOSIS: **1.** _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

SUMMARIZE CONDITION:

	CURRENT MEDICATION	DOSAGE	REASON FOR MEDICATION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Applicant Name:_____

ALLERGIES (List medication and food allergies)

1. _____ **3.** _____

2. _____ **4.** _____

Prosthetics: (List all glasses, dentures, wheelchairs, etc.)

_____

_____

_____

_____

PHYSICIANS

Physician: (Family M.D.)	**Address (City, State, Zip)**	**Telephone**
Date last seen	**Reason for visit**	
Physician: (Specialist)	**Address (City, State, Zip)**	**Telephone**
Date last seen	**Reason for visit**	
Physician: (Psychiatrist)	**Address (City, State, Zip)**	**Telephone**
Date last seen	**Reason for visit**	
Physician: (Dentist)	**Address (City, State, Zip)**	**Telephone**
Date last seen	**Reason for visit**	

LIST CURRENT THERAPY OR OTHER PHYSICIAN INFORMATION:

_____

_____

APPLICANT'S HISTORY

This information is useful in understanding a person's behavior, beliefs, and dominant ideologies. It is useful for therapist to understand a person's background to apply treatment.

Family	First	Last	Middle/Maiden	Living or Diseased (please list any cancer or other diseases prominent in family tree)
Mother:				
Father:				
Siblings:				
Children:				

Applicant Name:_____

Birthplace:

Where did the applicant grow up, if not same as birthplace?

Date in which Mental illness or Intellectual Disability was evident:

Please list any special events that provoke excitement from the past or present?

Please list any special events that provoke anger from the past or present? Please list any physical and mental abuse from past.

Please list any hospital admissions and reasons in the last 5 years:

Additional Comments: