

Previous Living Arrangements:

_____ / / to / /
_____ / / to / /

Family Information & Emergency Contacts

1. Father's Name: _____ Check if deceased
 Address: _____
 City/State/Zip: _____
 Telephone#: (____) _____ Date of Birth __/__/__ Social Security #: _____ - _____ - _____
 Work Phone#: (____) _____ Cell Phone#: (____) _____ Fax #: (____) _____
 Email Address: _____ Military Service No Yes What Branch? _____
 May we contact this person to get additional information? Yes No

2. Mother's Name: _____ Check if deceased
 Address: _____
 City/State/Zip: _____
 Telephone#: (____) _____ Date of Birth __/__/__ Social Security #: _____ - _____ - _____
 Work Phone#: (____) _____ Cell Phone#: (____) _____ Fax #: (____) _____
 Email Address: _____ Military Service No Yes What Branch? _____
 May we contact this person to get additional information? Yes No

(please list siblings oldest to youngest)

3. Sibling's Name: _____ Check if deceased
 Address: _____
 City/State/Zip: _____
 Date of Birth __/__/__ Do you have contact with this brother/sister? Yes No

Sibling's Name: _____ Check if deceased
 Address: _____
 City/State/Zip: _____
 Date of Birth __/__/__ Do you have contact with this brother/sister? Yes No

Sibling's Name: _____ Check if deceased
 Address: _____
 City/State/Zip: _____
 Date of Birth __/__/__ Do you have contact with this brother/sister? Yes No

(please use an additional sheet of paper if needed)

4. Alternate Emergency Contact:
 Name: _____ Relationship: _____
 Address: _____
 City/State/Zip: _____
 Work Phone#: (____) _____ Cell Phone#: (____) _____ Fax #: (____) _____
 Email Address: _____

Education History

1. School Name: _____

Address: _____

City/State/Zip: _____

Dates Attended: From ___/___/___ to ___/___/___

Did you receive any of the following: Diploma GED Certificate of attendance

School Name: _____

Address: _____

City/State/Zip: _____

Dates Attended: From ___/___/___ to ___/___/___

Did you receive any of the following: Diploma GED Certificate of attendance

School Name: _____

Address: _____

City/State/Zip: _____

Dates Attended: From ___/___/___ to ___/___/___

Did you receive any of the following: Diploma GED Certificate of attendance

Have you ever been tested by a psychologist? Yes No Results: _____

If yes, by whom? Name: _____

Date of testing: ___/___/___

Address: _____

City/State/Zip: _____

School Attendance: () Full Days () Half Days

() Homebound () None

Ride School Bus? Yes No

Employment History

Please list your most recent job first. Include all full-time and part-time employment, including sheltered workshop experiences, as well as military service assignments and volunteer activities. Attach an additional sheet if necessary.

1. Company Name: _____
 Address: _____
 City/State/Zip: _____
 Employment Dates: From ___/___/___ to ___/___/___ Position/Title: _____
 Supervisor: _____ Work performed: _____

 Major strengths and contributions in this position: _____

 May we contact this employer as a reference: Yes No
 Is this a sheltered workshop? Yes No

2. Company Name: _____
 Address: _____
 City/State/Zip: _____
 Employment Dates: From ___/___/___ to ___/___/___ Position/Title: _____
 Supervisor: _____ Work performed: _____

 Major strengths and contributions in this position: _____

 May we contact this employer as a reference: Yes No
 Is this a sheltered workshop? Yes No

3. Company Name: _____
 Address: _____
 City/State/Zip: _____
 Employment Dates: From ___/___/___ to ___/___/___ Position/Title: _____
 Supervisor: _____ Work performed: _____

 Major strengths and contributions in this position: _____

 May we contact this employer as a reference: Yes No
 Is this a sheltered workshop? Yes No

Financial Information

- Do you have cash on hand? Yes No Amount: \$ _____
- Do you have a savings account or investments? Yes No Amount: \$ _____
- Do you have a checking account? Yes No Amount: \$ _____
- If yes, do you need assistance with your checking account? Yes No Amount: \$ _____
- Do you receive SSI? Yes No Amount: \$ _____
- Do you receive SSDI? Yes No Amount: \$ _____
- Do you receive Social Security? Yes No Amount: \$ _____
- Do you have a Life Insurance policy? Yes No Amount: \$ _____
- Is there child support paid for you? Yes No Amount: \$ _____

Who is payor? _____
(Name)

Medical History

Do you have any of the following disabilities?

- mental retardation autism cerebral palsy
- other (please specify): _____

Do you have a physical disability? Yes No If yes, please explain: _____

Do you use any of the following?

- wheelchair walker brace(s) (please specify) _____ other (please specify) _____

Do you experience seizures? Yes No If yes, please explain: _____

Describe the type of seizure you experience: _____

How long do your seizures last? _____

In the past year, how frequently have you had seizures? _____

Age of seizure onset? _____ Date of last seizure: ____/____/____

Please list medications that you have taken in the past for your seizures:

Please indicate any of the following illnesses you have had:

Diabetes High Blood Pressure Hepatitis Tuberculosis Heart Problems Stomach Problems

Cancer Substance/Alcohol Abuse Other (please specify): _____

Have you been in the hospital recently? Yes No

If yes, please explain: _____

Name of hospital & dates hospitalized: _____

Have you had any surgeries? Yes No

If yes, please explain: _____

Name of hospital & dates hospitalized: _____

Do you require a special diet? Yes No If yes, please explain: _____

Do you have a gastrostomy tube for nutrition/hydration? Yes No If yes, please explain: _____

What formula? _____

Do you take anything orally? _____

Do you require staff be trained in special health procedures (i.e. ostomy care, positioning, adaptive devices, etc.)?

Yes No If yes, please specify: _____

Please list **current** medications, dosages, and reason you are taking them: _____

Do you need assistance in taking your medication? Yes No If yes, please explain: _____

Do you have any allergies? Yes No If yes, please list known allergies & reactions: _____

Name and address of preferred mortician (if none is listed, one will be assigned by the agency):

Name: _____

Address: _____

Primary Physicians Name: _____

Address: _____

City/State/Zip: _____

Date of last exam: ___ / ___ / ___ Telephone #: () _____

Dentist's Name _____

Address: _____

City/State/Zip: _____

Date of last exam: ___ / ___ / ___ Telephone #: () _____

Neurologist's Name: _____

Address: _____

City/State/Zip: _____

Date of last exam: ___ / ___ / ___ Telephone #: () _____

Orthopedic Doctor's Name: _____

Address: _____

City/State/Zip: _____

Date of last exam: ___ / ___ / ___ Telephone #: () _____

Psychiatrist's Name: _____

Address: _____

City/State/Zip: _____

Date of last exam: ___ / ___ / ___ Telephone #: () _____

Counselor's Name: _____

Address: _____

City/State/Zip: _____

Date of last exam: ___ / ___ / ___ Telephone #: () _____

Other Specialist's Name: _____

Address: _____

City/State/Zip: _____

Date of last exam: ___ / ___ / ___ Telephone #: () _____

Sensorimotor Abilities

Do you wear a hearing aid? Yes No

When was your last hearing evaluation? _____

By whom? _____

Describe your hearing loss: _____

Do you wear glasses? Yes No

Describe your visual impairment: _____

Describe your physical mobility: _____

Describe your ability to use your upper extremities: _____

Describe your communication skills: _____

Do you use a communication device? Yes No

If yes, explain: _____

Daily Routine

Describe a typical day: _____

Describe leisure activities you enjoy: _____

Any non-preferred daily activities? _____

Please indicate the amount of supervision required for the following:

Shaving: _____

Bathing: _____

Toothbrushing/Dental Care: _____

Dressing: _____

Toileting: _____

Nail Care: _____

Hair Care: _____

Eating: _____

Food Preferences: _____

Food Dislikes or Allergies: _____

Sleep Habits/Naps: _____

Cleanliness and Neatness: _____

Behavior

Indicate the frequency of each behavior:

(**Frequently** = several times a week; **Occasionally** = less than once a month)

Self Stimulatory Behavior Daily Frequently Weekly Monthly Occasionally None

Remove/Tear Own Clothes Daily Frequently Weekly Monthly Occasionally None

Eat/Drink Inappropriate Items Daily Frequently Weekly Monthly Occasionally None

Tantrum or Outburst Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Disrupt Others' Activities Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Verbally or Gesturally Abusive Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Self injurious Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Resist Supervision Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Destroy Property Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Display Sexually Inappropriate Behaviors Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Run Away Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Physically Assault Others Daily Frequently Weekly Monthly Occasionally None

Describe: _____

Steal Daily Frequently Weekly Monthly Occasionally None

Please list medications you have taken in the past for behavioral concerns:

Describe precautions taken in your home to insure or provide safety for you and others (closed or locked doors, restraints, bedrails, alarm system/monitors, night lights, room arrangements, articles placed out of reach, etc.)

Legal History

Have you ever been convicted of a crime? Yes No

If yes, of what and when? _____

Future Goals

What do you expect to gain from services at Hills & Dales?

Applicant: _____ Date: ____/____/____

Application completion support person: _____ Date: ____/____/____

Relationship to applicant: _____ Telephone #: (____) _____

PLEASE RETURN TO:

Hills & Dales Child Development Center

1011 Davis Street

Dubuque, IA 52001

Phone: (563) 584-2276

Fax: (563) 557-3822

Revised: 7/10/06 tkp, 7/19/06 hmb, 06/06/07 tkp, 8/29/07hmb

Date: 1/20/05 TKP

ATTACHED: Notice of Privacy Practices (AG517)