Application Processing Fee $50.00 Date: __________

RAINBOW OMEGA, INC.
APPLICATION FOR ADMISSION
P.O. Box 740 Eastaboga, AL 36260

__________________________________ __________________________________
Name of Applicant Date of Birth

____
Street Address

____
City State Zip

(_____) ______________________________
Telephone

Marital Status: ____never married; ____married; ____separated; ____divorced; ____widowed

Referred to Rainbow Omega, Inc. by ____

Services being sought:
___ Residential Care (which includes vocational training)
___ Respite only
___ Day Vocational Training only

Date Placement Desired:
___ as soon as possible
___ we're wanting to start the process,
but aren't needing placement right away

Nature of disability (i.e., mental retardation, autism, cerebral palsy, brain injury, Down syndrome, etc.):
____

Date diagnosed: __________

Please list three persons who have worked with or known the applicant personally.

a) Name ____ Phone (___) ______________
Address ____
Relationship: ___ family ___ friend ___ teacher ___ church ___ school ___ therapist

b) Name ____ Phone (___) ______________
Address ____
Relationship: ___ family ___ friend ___ teacher ___ church ___ school ___ therapist

c) Name ____ Phone (___) ______________
Address ____
Relationship: ___ family ___ friend ___ teacher ___ church ___ school ___ therapist

I. FAMILY & SOCIAL INFORMATION

1. Father's Name ____

Home Address ____
Street City State Zip

Home Phone: (___) __________________ Business Phone: (___) _________________

Occupation & Name of Company ____

____

If deceased? Date: ________________ Age: ______________

Cause: ____

2. Mother's Name ____

Home Address ____
Street City State Zip

Home Phone: (___) __________________ Business Phone: (___) _________________

Occupation & Name of Company ____

____

If deceased? Date: ________________ Age: ______________

Cause: ____

Has the applicant been adjudicated / declared legally incompetent? ___ no ___ yes
If yes:
Name of court appointed legal guardian: ____________________________________

Home Address ____
Street City State Zip

Home Phone: (___) __________________ Business Phone: (___) _________________

Occupation & Name of Company ____

____

** Enclose a copy of the court order if there's a legal guardian.*

3. Names of siblings | Date of births

4. Other significant people in his/her life | Relationship to him/her

5. Favorite activities:

6. Hobbies:

7. What is the applicant's primary mode of communication with others (e.g., speech, sign language, gestures, etc.)?

8. How does the applicant interact with friends and family:

9. Religious Affiliation: ____________________

10. What is the applicant's current schedule:

Morning: Gets up at ____________.

Afternoon:

Evening:

Night:

Goes to bed at ______________

11. Likes and Dislikes:

	Likes	Dislikes
Food		
TV		
Music		
Sports		
Outside Activities		
Restaurants		
Games		
Other		

II. SCHOOLS AND PROGRAMS ATTENDED

___ Applicant earned a high school diploma
___ Applicant earned a certificate of completion from high school
___ Applicant is still attending high school

Check all situations in which the applicant has participated. Please complete the information requested for each program.

a. _____ Group Home
b. _____ Independent Living
c. _____ State Institution
d. _____ Public Schools
e. _____ Competitive job
f. _____ Rehabilitation program
g. _____ Pre-vocational training
h. _____ Sheltered Workshop
i. _____ Day program
j. _____ Other ___________________

1) Name _______________________________________ Dates ________________

Address ____

Type Program (from above list) ____

Reason for leaving ____

Contact Person ____

Phone _______________________________

2) Name _______________________________________ Dates ________________

Address ____

Type Program (from above list) ____

Reason for leaving ____

Contact Person ____

Phone _______________________________

3) Name _______________________________________ Dates ________________

Address ____

Type Program (from above list) ____

Reason for leaving ____

Contact Person ____

Phone _______________________________

III. ACTIVITIES OF DAILY LIVING

1. Hygiene

a. showering	___ independent	___ assistance needed
b. brushing teeth	___ independent	___ assistance needed
c. shaving	___ independent	___ assistance needed
d. toileting	___ independent	___ assistance needed

2. Dressing

a. picking out clothing	___ independent	___ assistance needed
b. putting on clothing	___ independent	___ assistance needed

3. Laundry

a. sorting lights from darks	___ independent	___ assistance needed
b. setting the controls	___ independent	___ assistance needed
c. pouring the detergent in	___ independent	___ assistance needed
d. folding clothing	___ independent	___ assistance needed
e. hanging clothing	___ independent	___ assistance needed

4. Handling/Understanding money

a. can identify coins and bills	___ no	___ yes
b. understands the value of money	___ no	___ yes
c. understands how to make purchases	___ no	___ yes

5. Meals

a. can hold spoon/fork and eat without assistance	___ no	___ yes
b. can hold glass and drink without assistance	___ no	___ yes
c. can cut his/her food	___ no	___ yes

6. Preparing food

a. can prepare a simple item like a sandwich	___ no	___ yes
b. knows how to use a microwave	___ no	___ yes
c. knows how to use an oven	___ no	___ yes
d. knows how to use the stove	___ no	___ yes

7. Chores

a. can keeps room clean	___ no	___ yes
b. knows how to		
- sweep	___ no	___ yes
- mop	___ no	___ yes
- dust	___ no	___ yes
- load dishwasher	___ no	___ yes
- unload dishwasher	___ no	___ yes
- wipe off table/counters	___ no	___ yes
- fold towels	___ no	___ yes

IV. MEDICAL INFORMATION

The applicant or the applicant's guardian, parents or physician should complete the following information. All information is strictly confidential and will not be used for any purpose other than to guide Rainbow Omega, Inc. in providing care for the applicant. The information will not be released to any other facility, agency, or individual without the expressed written consent of the legally competent applicant or the guardian, parent, or responsible relative of an adjudicated incompetent applicant, or the legal agent holding power of attorney for an applicant.

1. Required Immunizations

Measles: Had measles or vaccinated with live measles vaccine since 1968. ___ no ___ yes

Mumps: Had mumps or vaccinated with live vaccine after 12 months of age. ___ no ___ yes

Rubella: Had rubella or vaccinated after 18 months of age. ___ no ___ yes

Tetanus & Diphtheria: Vaccinated first with a series of 3 doses (2nd dose 4-8 weeks after 1st dose; 3rd dose 6-12 months after 2nd dose). ___ no ___ yes

Date of last booster ______________________.

Polio: Series of Trivalent Oral Polio (OPV) vaccine at 2, 4, & 18 months of age or taken 4 doses of Inactive Polio Vaccine (IPV), continued IPV every 5 years until 18 years of age. ___ no ___ yes

Tuberculosis: Date of last negative chest X-ray or Tine Test: Date _______________________

Has applicant received flu vaccine before? ___ no ___ yes
If so, date______________________

Has applicant received pneumococcal vaccine? ___ no ___ yes
If yes, date______________________

Has applicant received 3 doses Hepatitis B vaccine? ___ no ___ yes
If yes, date ______________________

2. Sex ________ Height ____________ Weight ____________

3. Blood Type (if known) __________

4. Allergies:

Medication allergies ____

Food allergies ____

Allergy to pollens, insect bites, skin contact, substances? allergies_________________________

If on medication/injection for allergies, give name of physician, medication/injection dose and frequency. ____

5. Diet:

Is the applicant on any special diet (i.e., low calorie, low fat, diabetic diet, etc.)? ___ no ___ yes

If yes, was the diet recommended by his/her physician? ___ no ___ yes

If the applicant is on a diet, please describe it: ____

____

6. Health History

If you answer yes to any of the following, please give details. Use extra pages if necessary.

Condition	No	Yes	Details
Heart Trouble	___	___	______________________________________
Frequent Cold/Sinus Trouble	___	___	______________________________________
Headaches	___	___	______________________________________
Visual Problems	___	___	______________________________________
Glasses	___	___	______________________________________
Hearing Problems	___	___	______________________________________
Hearing Aid	___	___	______________________________________
Frequent Chest Infection	___	___	______________________________________
Asthma	___	___	______________________________________
Epilepsy	___	___	______________________________________
Tuberculosis	___	___	______________________________________
Kidney Disease	___	___	______________________________________
Obesity	___	___	______________________________________
Anemia	___	___	______________________________________
Stomach Trouble	___	___	______________________________________
Diabetes	___	___	______________________________________
Diarrhea	___	___	______________________________________
Fainting Spells	___	___	______________________________________
Menstrual Problems	___	___	______________________________________
Muscle Problems	___	___	______________________________________
Neurological Problems	___	___	______________________________________
High Blood Pressure	___	___	______________________________________
Other significant problems	___	___	______________________________________

7. Medications:

Medications	Dosage	Frequency	Prescribing Physician
____________________	_________	_________	____________________________
____________________	_________	_________	____________________________
____________________	_________	_________	____________________________
____________________	_________	_________	____________________________
____________________	_________	_________	____________________________
____________________	_________	_________	____________________________
____________________	_________	_________	____________________________
____________________	_________	_________	____________________________

8. Can the applicant swallow pills or does he/she need them crushed?
___ swallow whole ___ needs them crushed

9. Physicians

Primary Care Physician: ______________________

Address: ____

Phone number: ____

Dentist: ______________________

Address: ____

Phone number: ____

Ophthalmologist (vision): ______________________

Address: ____

Phone number: ____

Other: ____

Address: ____

Phone number: ____

10. Does the applicant have a fear of doctor or dental appointments or shots (beyond what's normal for most individuals)? ___ no ___ yes

If yes, please describe what helps: ____

____

____

____

11. Does the applicant have any of the following:

Prosthesis (eye, leg, etc.) ___ no ___ yes

If yes, please give details - ____

Wheelchair ___ no ___ yes

Cane ___ no ___ yes

Dentures ___ no ___ yes

If yes, are they: ___ upper ___ lower ___ both

Hearing aids ___ no ___ yes

If yes, are they: ___ right ___ left ___ both

Other ____

____

____

12. Past Surgeries, Hospitalizations, and major illnesses or injuries

Please indicate any past surgeries, hospitalizations, and major illnesses or injuries such as appendectomy, spinal meningitis, broken arm, etc. and dates they occurred.

____ __________

____ __________

____ __________

____ __________

____ __________

____ __________

13. Family Medical History

Has any member of the family ever had or been treated for any of the following: If yes, please explain and tell how they are related to the applicant.

Heart trouble: no ___ yes ______________________________

Lung trouble: no ___ yes ______________________________

High blood pressure: no ___ yes ______________________________

Low blood pressure: no ___ yes ______________________________

Stomach trouble (i.e. ulcers): no ___ yes ______________________________

Diabetes: no ___ yes ______________________________

Kidney trouble: no ___ yes ______________________________

Cancer: no ___ yes ___ type ______________________________

Thyroid trouble: no ___ yes ______________________________

Glaucoma: no ___ yes ______________________________

Epilepsy: no ___ yes ______________________________

Blood disorders or "free bleeding": no ___ yes ______________________________

Hepatitis: no ___ yes ______________________________

Nervous system (seizures, strokes, etc.): no ___ yes ______________________________

Other: ______________________________

____

14. Other Factors

Are there other medical factors, which would influence the care, health, and well-being of the applicant? ___ no ___ yes If yes, please describe:

____

____

Were there any problems with the pregnancy or birth of the applicant?
___ no ___ yes If yes, please describe:

____

____

V. PSYCHOLOGICAL / BEHAVIORAL

1. Has the applicant had a Psychological Evaluation?
   If yes, what is the date the evaluation was done and what was the Full Scale IQ (FSIQ)?
   Date: __________ FSIQ: __________

Reminder: We need a copy of a Psychological Evaluation performed after the age of 18 sent with this application.

2. Does the applicant receive care from a therapist, psychologist, or psychiatrist? ___ no ___ yes

If yes, please describe why: ____

____

____

3. Does the applicant have any psychiatric diagnosis, other than his/her developmental disability (e.g., depression, anxiety, schizophrenia, insomnia, etc.)? ___ no ___ yes

If yes, please state: ____

____

____

4. Has the applicant ever had any physically aggressive behavior (e.g., hitting, kicking, biting, etc.)?
___ no ___ yes

If yes, please describe: ____

____

____

5. Does the applicant ever become verbally aggressive (e.g., cursing, threatening, etc.)?
___ no ___ yes

If yes, please describe: ____

____

____

6. Describe how the applicant handles situations that make him/her sad:

____

____

7. Describe how the applicant handles situations that make him/her angry:

____

____

8. Describe what you believe is the most effective way of helping when the applicant is angry or sad:

____

____

9. Describe what you believe is the least effective way of helping when the applicant is angry or sad:

____

____

10. Does the applicant have any great fears or phobias (e.g., heights, the dark, loud noises, spiders)?
___ no ___ yes

If yes, please describe: ____

____

____

VI. VOCATIONAL

1. Has the applicant ever had job training? ___ no ___ yes
   If yes, where and when:

   Name: ____
   Dates: ___________________

   Name: ____
   Dates: ___________________

2. Has the applicant ever held a job? ___ no ___ yes
   If yes, where and when:

   Name: ____
   Dates: ___________________

   Name: ____
   Dates: ___________________

3. Can the applicant write? ___ no ___ yes
   If yes, how well? ____

4. Can the applicant read? ___ no ___ yes
   If yes, how well? ____

VII. FINANCIAL

Please be assured all information is strictly confidential and will only be shared with the business office in order to help determine finances.

Please describe any type of benefits the applicant receives through the Social Security Administration or any other type public or private financial assistance.

SSI: $___________ SS/SSA: $___________ Other: $__________

Use this space to describe any special problems you have had in finding assistance or benefits for the applicant?

Provided parent/guardian becomes deceased, who is appointed role of responsibility for the applicant? (Please give name, address, phone number, and relationship to applicant).

Do you know anything else special about your child that would assist us in providing the best possible care for him/her?

I affirm that the information contained in this application is, to the best of my knowledge and belief, a complete and true statement of facts and circumstances relative to the applicant and family.

______________________________	______________________
Signature/Mark of Applicant	Date
______________________________	______________________
Signature of Parent/Guardian/Family Member	Date
______________________________	______________________
Signature of person completing the application if different from above.	Date