Thank you for your interest in Benedictine Adult Services. Please complete the application in its entirety. In addition to the application, all applicants need to submit the following information in order for the Admissions Committee to review and make a decision on acceptance:

- Copy of identification card
- Medical and social histories

The following information must accompany application and be current (within a year from application submittal):

- Recent annual planning document (IEP/IP/Person-Centered Plan)
- Psychological and/or psychiatric evaluation (within a year of)
- Physical exam records
- Dental exam records

If you have any questions regarding our criteria and procedures, please see the Admission Policy for in depth information. Please understand that until all of the above information is received, the application will not be reviewed.

If accepted, the following information is required:

- Copy of Medical Assistance card
- Copy of Social Security card
- Certified copy of birth certificate

Finally, if accepted the following information will be requested but all information may not be applicable to every applicant:

- Residential records
- Vocational/employment records
- DORS and/or community employment evaluation
- Current or past behavior plan
- Copies of Legal Documents / Guardianship

It is the applicant's responsibility to submit all required information according to the appropriate time frames to the Admissions Committee.

14299 Benedictine Lane * Ridgely, Maryland 21660
Phone: 410.634.1990
adultadmissions@benschool.org

Please attach a recent picture of applicant here.

APPLICATION FOR SERVICES

Check Waivers for which application is submitted:

☐ Community Pathways ☐ Community Supports ☐ Family Supports

☐ Check here if non-waiver funded

List Services Requested:

1.

2.

3.

4.

5.

6.

Anticipated Start Date:_____

** Fill out the following sections as instructed – not all information may apply*

A. Applicant's General Information

Name of Applicant:_____

Address:_____
(Street) (City) (State) (Zip)

Phone:_____ Social Security #:_____

Date of Birth:_____Birthplace:_____ Gender: ☐ female ☐ male

Legal Guardian Name (if applicable):_____

_____
(Street) (City) (State) (Zip)

Phone: (Home)_____(Cell)_____(Work)_____

Does the Applicant have a Maryland Coordinator of Community Supports/Service Coordinator?

_____
(Name)

_____
(County, State) (Phone) (Fax)

What does the individual do during the day?

Employment/School/Day Program:_____

_____
(Street) (City) (State) (Zip)

Contact Person:_____Phone:_____

Please list any other Providers/Agencies involved:

Name of Program	Contact Person	Phone

B. Family Information

Father (or guardian)	**Mother (or guardian)**
Name: _____	Name:_____
Address:_____	Address:_____

(County) (City)

(State) (Zip)

Date of Birth:

Occupation:

Phone: (Home)

(Cell)

(Work)

Email:

(County) (City)

(State) (Zip)

Date of Birth:

Occupation:

Phone: (Home)

(Cell)

(Work)

Email:

Name of person to be notified in an emergency (other than either of the above):

Name: Relationship:

Phone: (Home) (Cell) (Work)

Does the individual have any siblings?

Name	Age

C. Funding

Does the person have funding for services: ☐ Yes ☐ No, why:

STOP HERE IF NOT APPLYING FOR RESIDENTIAL, PERSONAL SUPPORTS, OR EMPLOYMENT/DAY SERVICES.

D. Specific Applicant Information

1. Communication *(Check any which are appropriate and explain, if necessary)*

☐ communicates in sentences
☐ uses sign languages
☐ uses some words
☐ does not understand commands
☐ uses flash cards/picture books
☐ uses a communication device
☐ does not use words
☐ understands some/most commands

Comments:_____

_____

_____

2. Eating Habits *(Check any which are appropriate and explain, if necessary)*

☐ independent
☐ dependent
☐ needs pureed food
☐ has history of choking
☐ assistance with preparation
☐ needs assistance eating
☐ uses feeding tube
☐ has choking protocol

Comments:_____

_____

_____

3. Bathing/Hygiene

Assistance in/out of tub:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance with bath/shower:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance shaving:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Menstrual needs:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance dressing:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance tooth brushing:	☐ independent	☐ supervised	☐ dependent	☐ N/A
Assistance with hair care:	☐ independent	☐ supervised	☐ dependent	☐ N/A

Comments:_____

_____

_____

4. Toileting *(Check any which are appropriate and explain, if necessary)*

☐ continent
☐ sometimes incontinent
☐ stress incontinent
☐ uses Depends at night only
☐ frequent UTI
☐ toilets independently
☐ always incontinent
☐ night time incontinent
☐ uses Depends during day and night
☐ has doctor's order for use of Depends
☐ has Urinary/Foley catheter
☐ requires assistance with toileting

Comments:_____

_____

_____

5. Sleep Habits

Does individual have a usual bedtime? ☐ Yes ☐ No What time?_____

Does individual take a nap? ☐ Yes ☐ No What time?_____

Does individual use breathing device: ☐ Yes ☐ No

If yes, what type of device:_____

Does individual wake up during the night? ☐ Yes ☐ No

If so, what should be done?_____

Comments:_____

_____

6. Mobility *(Check any which are appropriate and explain, if necessary)*

☐ walks independently
☐ walks, but needs assistance
☐ wheelchair used sometimes
☐ wheelchair used all the time
☐ able to transfer from wheelchair to chair
☐ uses cane/crutches
☐ uses a walker
☐ able to climb stairs

Comments:_____

_____

E. Personal Information

Please list any hobbies:

_____

_____

_____

Is the individual social? What social activities are of interest?

_____

_____

_____

Does the individual attend regular religious services? (Please list name and address)

_____

_____

_____

Does the individual have favorite TV shows or movies?

_____

_____

_____

Does the individual do any chores (vacuuming, setting table, taking trash out…) in the home?

_____

_____

_____

Does the individual have any fears Benedictine should be aware of?

_____

_____

_____

Please describe the individual's personality traits:

_____

Does the individual like/dislike any animals?

Describe the ability of the individual to cope with change in daily routine?

Does the individual read and write?

Is the individual able to remain home unsupervised? How long? Any restrictions/considerations?

Does the individual have any behaviors that have been of concern?

Does the individual have a formal behavior plan?
☐ Yes ☐ No Developed by:_____

Has the individual ever been convicted of a crime? ☐ Yes ☐ No
If yes, please explain:_____

F. Medical and Health Information

1. Diagnosis

2. Any Allergies (medications or environmental):_____

3. Height: _____ Current Weight:_____lbs._____

4. Immunizations:

Hepatitis B Vaccine:	☐ Yes	☐ No	Date: _____	
Hepatitis B Carrier:	☐ Yes	☐ No	☐ Unknown	
PPD (TB test):	☐ Yes	☐ No	Date: _____	☐ Positive ☐ Negative
MRSA Carrier:	☐ Yes	☐ No	☐ Unknown	
Tetanus:	☐ Yes	☐ No	Date: _____	

Measles, Mumps, Rubella: ☐ Yes ☐ No Date: _____
Flu Shot: ☐ Yes ☐ No Date: _____
Pneumonia vaccine: ☐ Yes ☐ No Date: _____

Does Applicant have a contagious condition? ☐ Yes ☐ No
If yes, explain:_____

5. Does the individual need assistance with taking medication?

☐ Yes, complete assistance ☐ Needs prompting to take ☐ Self Administrating

6. How does the individual take their medication?

☐ Takes medication without difficulty (give with 8 ounces of fluid/water)
☐ Crushed pills/tablets
☐ Takes with applesauce or other soft food item
☐ Liquid form of medication
☐ Liquid form with thick it
☐ G-tube only, nothing by mouth
☐ Other:_____

7. Has the individual ever had a choking incident? ☐Yes ☐ No

8. Has the individual ever had pneumonia? ☐ Yes ☐ No Date:_____

9. List any adaptive equipment and specify time when used (helmet, eating utensils, splint, AFO...)

Adaptive Equipment *Example: Splint on right hand*	Time Adaptive Equipment is used *Example: at bed time during sleep hours*
_____	_____
_____	_____
_____	_____
_____	_____

10. Seizures

Does individual experience seizures? ☐ Yes ☐ No
Do seizures last longer than 5 minutes? ☐ Yes ☐ No How long:_____mins._____
Frequency? ☐ daily ☐ weekly ☐ monthly ☐ other:_____

Describe Seizures: *(Example: unresponsive, one side of arm or leg jerks, drooling, bluish facial color, will tell you has funny feeling in head, sleeps after seizures for 30-45 minutes, incontinent…)*

_____
_____
_____

How long after their seizure do they sleep?_____

During/after seizure are there any special procedure/medications to be given?_____
_____
_____

11. Last Physical:_____ Findings/Concerns:_____

_____

12. Physicians/Health Care Provider *(Please skip if you are not applying for Residential Services)*

Primary Physician (PCP):_____ Phone: _____

_____

(Street) (City) (State) (Zip)

Date of last visit:_____ Reason:_____

Dentist:_____ Phone: _____

_____

(Street) (City) (State) (Zip)

Date of last visit:_____ Reason:_____

Psychiatrist:_____ Phone: _____

_____

(Street) (City) (State) (Zip)

Date of last visit:_____ Reason:_____

Psychologist:_____ Phone: _____

_____

(Street) (City) (State) (Zip)

Date of last visit:_____ Reason:_____

Specialist:_____ Phone: _____

_____

(Street) (City) (State) (Zip)

Date of last visit:_____ Reason:_____

Specialist:_____ Phone: _____

_____

(Street) (City) (State) (Zip)

Date of last visit:_____ Reason:_____

Specialist:_____ Phone: _____

_____

(Street) (City) (State) (Zip)

Date of last visit:_____ Reason:_____

Hospital familiar with individual:_____

13. Medication List:

Name	Dose	Frequency	Route
EXAMPLE MEDICATION	100mg	3x per day	By mouth
Name	**Dose**	**Frequency**	**Route**

14. General Health *(Please check all that apply):*

☐ Impaired ability to carry out activities of daily living
☐ Sleeps during the night time hours
☐ Has difficulty sleeping or falling asleep during night time hours
☐ Do they nap/sleep during the day time hours? Times:_____
☐ Any presence of old scars, bumps or lumps? Specify:_____
☐ History of sinus infections
☐ History of nose bleeds
☐ Difficulty chewing or swallowing
☐ Date of last dental exam: _____
☐ Use of dentures or bridges
☐ Overall description of teeth (scattered teeth, missing, no teeth) _____
☐ History of eye problems
☐ Use of corrective lens (glasses) Rt. _____ Lt. _____
☐ History of cataracts or glaucoma ☐ Cataracts removed Date:_____
☐ Abnormal sensitivity to noise or touch
☐ History of ear infections
☐ Legally blind
☐ Uses a hearing aid Rt. _____ Lt. _____
☐ History of pneumonia or bronchitis
☐ Difficulty breathing (wheezing, asthma, or other breathing problems)
☐ Needs to sit up to breathe, especially at night
☐ Swelling of ankles or feet or other areas of the body _____
☐ Discoloration of fingers, toes or other parts of the body _____
☐ History of stomach ulcers, vomiting blood
☐ History of refluxing, pain upon eating or nausea
☐ History of constipation
☐ History of diarrhea
☐ Changes in bowel elimination pattern
☐ History of hemorrhoids
☐ Use of laxatives, stool softeners

☐ Use of high fiber diet or prune juice or other natural fiber
☐ Uses toilet schedule for urination/BMs Specify:_____
☐ History if urinary tract infections
☐ Does the individual smoke/drink alcohol? Specify:_____
☐ History of fainting or loss of consciousness
☐ History of nervous system problem

☐ History of cognitive disturbances, including recent or remote memory loss, hallucinations, disorientation or inability to concentrate
☐ History of speech and language dysfunction
☐ History of motor problems, including problems with gait (walking), balance, tremors or spasm paralysis
☐ Interference by cognitive, sensory, or motor symptoms with ADLs
☐ History of fractures Specify:_____
☐ History of joint deformities or contractures
☐ Spinal deformity
☐ Chronic back problems (spinal rods)
☐ History of anemia
☐ History of easy bruising
☐ History of thyroid problems, adrenal problems, diabetes
☐ Any open sores, wounds or rashes on body area Specify:_____
☐ Heat or cold intolerance
☐ Increases thirst
☐ Unexplained changes in weight (increase or decrease)
☐ PAP for female older than 40 years
☐ History of mental illness (bipolar, OCD…) Specify:_____

15. Medical Insurance/Policy Numbers:_____

_____

_____

16. Any additional medical/health information/concerns:_____

_____

_____

17. Does the individual have an advanced directive? ☐ Yes ☐ No

G. Educational/Employment Background

1. Schools Attended

School/Address	Year	Grade Accomplished

2. Other Programs Attended

Facility/Address	Year	Grade Accomplished

3. Job Training, Volunteer, and/or Employment

Job Training/Place of Employment	Position	Date	Reason Left

4. Present Job Placement:_____

Hours per week:_____hrs._____ Earning per hour/week/month: $_____per_____

H. Transportation

For Employment/Day Services only:

Does Individual have reliable transportation for employment purposes? ☐ Yes ☐ No

Has Individual utilized any type of public transportation? ☐ Yes ☐ No

If yes, please indicate which public transportation service was used: _____

_____

_____

Does Individual require any special accommodations for transportation (ex. wheelchair accessible)?

☐ Yes ☐ No If yes, please indicate_____

_____

_____

I. Representative Payee Information *(Please skip if you are not applying for Residential Services)*

Name of Rep Payee:_____Phone:_____

_____

(Street) (City) (State) (Zip)

I elect Benedictine Adult Services to become Rep Payee: ☐ Yes ☐ No

J. Other Benefits Information *(Please skip if you are not applying for Residential Services)*

Does the individual receive Food Stamps? ☐ Yes ☐ No

If yes, what County? _____Food Stamp ID#:_____

SSI Claim Number:_____SSI Amount: $_____

SSA Claim Number:_____SSA Amount: $_____

SSDI Claim Number:_____SSDI Amount: $_____

Does individual have a burial plan?_____

Burial Plot Location:_____ Estimated Value: $_____

Life Insurance Coverage:_____

Does the individual have a trust fund? ☐ Yes ☐ No

If yes, type:_____

Name of Rep Trustee:_____ Phone:_____

_____

(Street) (City) (State) (Zip)

Does individual have a Bank Account? ☐ Yes ☐ No Bank Name:_____

I understand that the application information is for the purpose of assisting Benedictine Adult Services in serving me now and/or planning with me for the future. I understand that all information will be treated in a strictly confidential manner.

_____ _____

Signature of Applicant (if at least 18 years old) or guardian Date

_____ _____

Signature of Person Completing Application Date

Benedictine Adult Services places no restrictions as to the applicant's race, color, creed, national origin, political affiliation, marital status, age, sex, sexual orientation or disability. Benedictine is an Equal Opportunity Service Provider.