



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.



Benedictine Adult Services
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 Services for which application is submitted:

- Community Living Group Home
- Supported Living
- Personal Support
- Community Development Services
- Employment Supports

Funding Source:

- Traditional Waiver
- Self-Directed
- Private Pay

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:

<u>Name of Program</u>	<u>Contact Person</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Family Information

Father (or guardian)

Mother (or guardian)

Name: _____

Name: _____

Address: _____

Address: _____

(County) (City)

(County) (City)

(State) (Zip)

(State) (Zip)

Date of Birth: _____

Date of Birth: _____

Occupation: _____

Occupation: _____

Phone: (Home) _____

Phone: (Home) _____

(Cell) _____

(Cell) _____

(Work) _____

(Work) _____

Email: _____

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*)

- | | |
|---|---|
| <input type="checkbox"/> communicates in sentences | <input type="checkbox"/> uses flash cards/picture books |
| <input type="checkbox"/> uses sign languages | <input type="checkbox"/> uses a communication device |
| <input type="checkbox"/> uses some words | <input type="checkbox"/> does not use words |
| <input type="checkbox"/> does not understand commands | <input type="checkbox"/> understands some/most commands |

Comments: _____

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

- | | |
|---|--|
| <input type="checkbox"/> independent | <input type="checkbox"/> assistance with preparation |
| <input type="checkbox"/> dependent | <input type="checkbox"/> needs assistance eating |
| <input type="checkbox"/> needs pureed food | <input type="checkbox"/> uses feeding tube |
| <input type="checkbox"/> has history of choking | <input type="checkbox"/> has choking protocol |

Comments: _____

3. Bathing/Hygiene

- | | | | | |
|------------------------------|--------------------------------------|-------------------------------------|------------------------------------|------------------------------|
| Assistance in/out of tub: | <input type="checkbox"/> independent | <input type="checkbox"/> supervised | <input type="checkbox"/> dependent | <input type="checkbox"/> N/A |
| Assistance with bath/shower: | <input type="checkbox"/> independent | <input type="checkbox"/> supervised | <input type="checkbox"/> dependent | <input type="checkbox"/> N/A |
| Assistance shaving: | <input type="checkbox"/> independent | <input type="checkbox"/> supervised | <input type="checkbox"/> dependent | <input type="checkbox"/> N/A |
| Menstrual needs: | <input type="checkbox"/> independent | <input type="checkbox"/> supervised | <input type="checkbox"/> dependent | <input type="checkbox"/> N/A |
| Assistance dressing: | <input type="checkbox"/> independent | <input type="checkbox"/> supervised | <input type="checkbox"/> dependent | <input type="checkbox"/> N/A |
| Assistance tooth brushing: | <input type="checkbox"/> independent | <input type="checkbox"/> supervised | <input type="checkbox"/> dependent | <input type="checkbox"/> N/A |
| Assistance with hair care: | <input type="checkbox"/> independent | <input type="checkbox"/> supervised | <input type="checkbox"/> dependent | <input type="checkbox"/> N/A |

Comments: _____

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

- | | |
|---|--|
| <input type="checkbox"/> continent | <input type="checkbox"/> always incontinent |
| <input type="checkbox"/> sometimes incontinent | <input type="checkbox"/> night time incontinent |
| <input type="checkbox"/> stress incontinent | <input type="checkbox"/> uses Depends during day and night |
| <input type="checkbox"/> uses Depends at night only | <input type="checkbox"/> has doctor's order for use of Depends |
| <input type="checkbox"/> frequent UTI | <input type="checkbox"/> has Urinary/Foley catheter |
| <input type="checkbox"/> toilets independently | <input type="checkbox"/> 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. Diagnoses

2. Any Allergies (medications, environmental or food): _____

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: _____
 COVID 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.