BVT
Breckenridge Village of Tyler

*Date of Application*_____

*Date Received at BVT* _____

**BRECKENRIDGE VILLAGE OF TYLER**
**ADMISSION APPLICATION**

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Requested Placement: (Check Appropriate Box) □ Day Program □ Residential

APPLICANT'S NAME_____
(Last) (First) (Middle)

Address_____
(Street address) (City) (State) (Zip)

Date of Birth_____Place of Birth_____Sex____Height_____Weight_____

Marital Status _____ Usual Occupation_____

Social Security Number_____

FATHER'S NAME _____Home Ph. #( )_____

Home address_____
(Street address) (City) (State) (Zip)

Occupation_____ Bus. Ph. #( )_____

MOTHER' NAME_____Home Ph. #( )_____

Home address_____
(Street address) (City) (State) (Zip)

Occupation_____Bus. Ph. #( )_____

Email Address: _____

LEGAL GUARDIAN (If other than parent)_____

Relationship_____

Home Address_____

Home Phone #_____Business Phone #_____

## GENERAL SOCIAL INFORMATION

Has the applicant had any of the following? If yes, give name of the person or agency. Include copies of reports from this person/agency.

| | Yes | No | Dates | Person/Agency |
|---|---|---|---|---|
| Psychological evaluation | [ ] | [ ] | _____ | _____ |
| Psychological counseling | [ ] | [ ] | _____ | _____ |
| Psychiatric evaluation | [ ] | [ ] | _____ | _____ |
| Psychiatric hospitalization | [ ] | [ ] | _____ | _____ |
| Speech/language assessment | [ ] | [ ] | _____ | _____ |
| Medical evaluation | [ ] | [ ] | _____ | _____ |

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Please answer the following questions. Attach additional pages as needed.

1. Describe applicant's general health, including specific medical problems and/or disabilities.

_____
_____
_____
_____

2. Describe applicant's social/emotional state **most** of the time. (For example: withdrawn, hyper-verbal, frustrated, sociable, even-tempered, etc.

_____
_____
_____

3. Does he/she prefer to be with peers, family, someone older or be alone? Explain:

_____
_____
_____

4. Please check which of the following applies to the applicant:

[ ] likes people
[ ] gets along well with friends
[ ] follows directions willingly
[ ] shows concerns for others
[ ] tends to be a loner
[ ] respects rights & property of others
[ ] gets angry easily
[ ] courteous to others
[ ] tends to be shy initially
[ ] can introduce self
[ ] forms close relationships
[ ] is generally happy

5. Describe how the applicant reacts when he/she gets angry. (For example: pouts, tantrums, aggressive, etc.)

_____
_____

6. Does the applicant require constant at-home supervision? [ ] Yes [ ] No
Can the applicant be left at home to function independently? [ ] Yes [ ] No
If yes, for what period of time? _____

7. Has the applicant ever been involved with the following?

| | | |
|---|---|---|
| Tobacco | [ ] Yes | [ ] No |
| Drugs | [ ] Yes | [ ] No |
| Alcohol | [ ] Yes | [ ] No |
| Criminal activity | [ ] Yes | [ ] No |
| Sexual activity | [ ] Yes | [ ] No |

If yes, please explain: _____
_____

8. Which of the following apply to the applicant's speech/language and communication skills?
[ ] speaks spontaneously
[ ] communicates basic needs
[ ] uses complete sentences
[ ] uses sign language
[ ] has small vocabulary
[ ] understands lengthy dialogue
[ ] makes little or no effort to communicate verbally or with gestures
[ ] understands short, direct commands
[ ] communicates by writing
[ ] comprehends written statements
[ ] uses gestures effectively
[ ] uses sentences effectively
[ ] uses idiosyncratic gestures

9. Describe the applicant's speech and language effectiveness:

_____
_____
_____
_____

# SELF-HELP SKILLS

**MEALS:**
[ ] No assistance needed
[ ] Some assistance needed
[ ] Total assistance needed
[ ] Food needs to be cut/chopped
[ ] Needs a straw for liquids
Special instructions: _____

**SHOWERS:**
[ ] No assistance needed
[ ] Some assistance needed
[ ] Total assistance needed
[ ] Help shampooing hair only
Special instructions: _____

**DRESSING:**
[ ] No assistance needed
[ ] Some assistance needed
[ ] Total assistance needed
[ ] Needs help with buttons/zippers
Special instructions: _____

**MOBILITY:** (check all that apply)
Uses: [ ] Walker [ ] Braces [ ] Crutches
[ ] Manual wheelchair [ ] Electric wheelchair [ ] No assistance needed

**TOILETING:**
[ ] No assistance needed [ ] Help transferring [ ] Help cleaning up
[ ] Wets bed [ ] Diapers/Depends [ ] Day [ ] Night [ ] Both
[ ] Bowel control [ ] Limited [ ] No control
[ ] Bladder control [ ] Limited [ ] No control
Special instructions: _____

| | | | |
|---|---|---|---|
| Wash face | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |
| Brush teeth | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |
| Comb hair | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |
| Trims fingernails | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |
| Trims toenails | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |
| Use deodorant | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |
| Can shave | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |
| Manages menstrual period (if applicable) | | | |
| | [ ] Needs no help | [ ] Needs some help | [ ] Needs total help |

## INTELLECTUAL & DEVELOPMENTAL DISABILITIES SERVICES

Check all services and supports that the applicant is receiving currently related to IDD services. Attach additional documentation if applicable. (Ex: Person Directed Plan (PDP), Inventory for Client Assessment and Planning (ICAP), etc.)

Local IDD Authority or Private Provider Services & Supports:

[ ] General Revenue
[ ] STAR + Waiver
[ ] Intermediate Care Facilities for IDD
[ ] Texas Home Living
[ ] CLASS
[ ] Home and Community Based Services (HCS)

Unsure if the applicant receives these program services, please check any of the below that apply:

[ ] Service Coordinator/Case Manager comes to see them
[ ] Receives Personal Attendant Services or Respite
[ ] Attends a Day Habilitation Program that someone else pays for
[ ] Receives Foster Care/Host Home Services
[ ] Resides in a group home (3/4 bed= HCS; 6 + = ICF)

If currently receiving IDD services and supports please list the contact information for your Local IDD Authority or Private Provider:

Contact Name: _____ Phone #: _____

Address: _____

Email Address: _____ Fax #: _____

Has the applicant received Behavior Management Services from the Local IDD Authority or a Private Provider? If so, please explain:

_____
_____
_____
_____

## SCHOOLS OR PROGRAMS ATTENDED

Check all situations in which the applicant participated and complete the following information on each situation. Attach additional pages if needed.

[ ] Public education: Graduate _____ Age _____
[ ] Day school
[ ] Sheltered workshop
[ ] Group/family care home
[ ] Independent living
[ ] Competitive employment
[ ] State school
[ ] Private school
[ ] Other _____

Name of facility _____ Dates attended _____

Address _____ Phone # _____

Type of situation (refer to above list) _____

Reason for leaving _____

Person to contact for more information _____

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Name of facility _____ Dates attended _____

Address _____ Phone # _____

Type of situation (refer to above list) _____

Reason for leaving _____

Person to contact for more information _____

**********

Name of facility _____ Dates attended _____

Address _____ Phone # _____

Type of situation (refer to above list) _____

Reason for leaving _____

Person to contact for more information _____

## MEDICAL HISTORY

Name of applicant's primary physician: _____

Address:_____ Phone #_____

Has the applicant had a physical exam within the past six months? [ ] Yes [ ] No

Name of dentist: _____

Address: _____ Phone # _____

List names of other specialists who have treated or are treating the applicant:
_____
_____

Is the applicant on any regular medications/food supplements? [ ] Yes [ ] No
If yes, please list: _____
_____
_____

Is the applicant allergic to any medications? [ ] Yes [ ] No
If yes, please list: _____
_____

Is the applicant allergic to anything: foods, pollens, insect bites, etc.? [ ] Yes [ ] No
If yes, what and describe reactions and what treatment is usually necessary: _____
_____

Does the applicant have any special dietary needs? If yes, please explain: _____
_____

If on medication/injection for allergies, give names of medication/injection?
_____

Since some conditions can be hereditary, or run in families, please indicate which family member:
Hypertension _____ Stroke _____ Heart attack _____
Kidney disease _____ Diabetes _____ Gout _____
Cancer _____ Intellectual Disability _____ Arthritis _____
Epilepsy _____ Other _____

## HEALTH HISTORY

If the resident is prone to or has problems with any of the following, please answer "Yes." If "Yes," explain in the space provided. Also list the preferred treatment. If extra space is needed, please use a separate piece of paper and attach to this Form.

| | NO | YES | COMMENTS |
|---|---|---|---|
| Anemia | | | |
| Cold/Sinus trouble | | | |
| Headaches | | | |
| Eyes | | | |
| Glasses (attach prescription) | | | |
| Ears | | | |
| Hearing | | | |
| Chest infections | | | |
| Asthma | | | |
| Shortness of breath | | | |
| Epilepsy | | | |
| Heart trouble | | | |
| High blood pressure | | | |
| Kidney disease | | | |
| Liver disease | | | |
| Stomach trouble | | | |
| Diabetes | | | |
| Bleeding problems | | | |
| Diarrhea or constipation | | | |
| Rheumatic Fever | | | |
| Fainting spells | | | |
| Menstrual problems | | | |
| Muscle problems | | | |
| Neurological problems | | | |
| Emotional problems | | | |
| Psychological problems | | | |
| Psychiatric problems | | | |
| Other: | | | |
| | | | |