BRECKENRIDGE
VILLAGE

*Date of Application*_____

APPLICATION FOR SERVICES

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

APPLICANT'S NAME _____

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

Date of Birth _____ Place of Birth _____ Sex _____

Marital Status _____ Usual Occupation _____ Cell # ( ) _____

Social Security Number _____ Email Address: _____

FATHER'S NAME _____ Direct Ph. #( )_____

Home address _____
○ Same as applicant (Street address) (City) (State) (Zip)

Email Address: _____

Occupation _____ Alt Ph. #( )_____

MOTHER' NAME _____ Direct Ph. #( ) _____

Home address _____
○ Same as applicant (Street address) (City) (State) (Zip)

Email Address: _____

Occupation _____ Alt Ph. #( )_____

LEGAL GUARDIAN (If other than parent) _____

Relationship _____ Email Address: _____

Address _____
○ Same as applicant (Street address) (City) (State) (Zip)

Direct Phone # ( ) _____ Business Phone #( ) _____

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Applicant Name: _____

GENERAL SOCIAL INFORMATION

We try to understand everyone as completely as we can. Obviously, this isn't easy from looking at words on a page. We encourage you to visit Breckenridge Village and meet with us. Help us get to know you on a personal level.

And, if you can, please ***attach a photograph*** of yourself, this helps us remember you. As you know, names can get mixed up, but it's hard to forget a face.

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

All of these questions are asked about the person applying for admission, but other people are involved in this process, so include information as it helps us understand you.

1. Everyone is on a journey, and it is often difficult to see where someone has been based on where they are. Please share some highlights of your journey. What events in your past are important to know now? What were the important milestones on your path to Breckenridge Village?

_____
_____
_____
_____
_____
_____
_____
_____

2. Describe your general health, including any special challenges you face.

_____
_____
_____
_____

3. Where did you go to school? Have you worked for wages or in a sheltered environment?

_____
_____

4. How do you feel most of the time? Are you generally happy? Or shy? What general events can affect your mood?

_____
_____
_____

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5. With whom do you like to be around? Who are your friends? Who is your biggest supporter? To whom do you confide when things are difficult?

_____

_____

_____

6. Everyone gets angry now and again, how will you show you are upset, and how can we help you through that time?

_____

_____

_____

_____

_____

7. Rank yourself on the following continuums (place an X on the line):

Likes people a lot ---------- Doesn't care for people

Has a lot of friends ---------- Has a few close friends

Follows directions right away ---------- Wants to understand instructions

Cares about the feelings of others ---------- Doesn't worry about others

Likes to be around others ---------- Prefers to be alone

Respects other's property ---------- May not understand ownership

Handles change well ---------- Needs time to process change

Happy ----------Upset

Courteous ---------- Self Absorbed

Outgoing ---------- Shy

Listens to others ---------- Doesn't want to be told

Independent ---------- Values Assistance

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8. Can you stay home alone? _____ For how long? _____

9. Do you ever get lost in a crowd? What do you do when you're scared? _____
_____
_____

10. What experience do you have with relationships? Is an intimate relationship one of your goals? Do you understand the responsibilities that come with relationships?

_____
_____
_____

11. What special skills do you have (like cooking or household chores or sports)? Do you have any skills people may not expect?

_____
_____
_____
_____

12. How do you communicate? How well do others understand you? How patient are you?

_____
_____
_____
_____

13. Have you ever been involved with the legal system (police and courts)?

_____
_____

14. Breckenridge Village is a drug and alcohol-free campus, do you currently use or have a history of using substances that change how you think or feel (that were not prescribed by a doctor)?

Tobacco	[ ] Yes [ ] No
Drugs	[ ] Yes [ ] No
Alcohol	[ ] Yes [ ] No

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SELF-HELP SKILLS

The tasks we complete often are usually called "The Activities of Daily Living", which is a fancy way of saying, "What I do every day" and include a bunch of items. Help us understand what sort of help you might need in your day…

Meals:
- o I'm a great cook
- o I need some help preparing my meal
- o I'm not interested in cooking

Eating:
- o I eat without help
- o I need somethings changed
- o I need some reminders
- o I need a lot of help with eating

Bathing:
- o I got this, don't worry
- o I need some help with some things
- o I'm not so good at this yet

Getting dressed/undressed:
- o I'm great at fashion
- o I'll want some guidance
- o It's hard to match things
- o I have a hard time with buttons
- o Zippers are not easy for me

Using the restroom:
- o Privacy please, don't come in
- o I need some help getting settled
- o I need some help to be clean
- o My body has a hard time waiting
- o I have special under clothes to help

Community safety:
- o I navigate my town easily
- o I need directions
- o It's best if I have a travel buddy
- o Pedestrian safety is difficult

Home Safety:
- o I'm very safe at home
- o I forget to lock the door
- o I am friendly with everyone

Online safety:
- o I'm social on my media
- o I overshare with people
- o I have to have some limits
- o Social Media is overwhelming
- o The people who love me most don't think Social Media is right for me

Hygiene Tasks:

I marked the ones where I need help:
- o Wash face
- o Brush teeth
- o Comb hair
- o Trims fingernails
- o Trims toenails
- o Use deodorant
- o Shaving
- o Feminine Hygiene
- o Washing hands in the restroom
- o Washing hands before meals

Some of the items you've marked may need some explanation, like what help you need with certain things. Or maybe you have some other item needs attention.

_____

_____

_____

_____

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HEALTH HISTORY

Everyone has challenges with their health. To know how to help everyone, it's best that we know about your challenges. Here's a list of challenges that others have reported. If you have some that are not on the list, add them to the bottom. In the comments, describe the details and if there is a preferred treatment.

	YES	COMMENTS
Headaches		
Migraines		
Poor Sight		
Difficulty Hearing		
TMJ		
Allergies		
Sinus Issues		
Ear Infections		
Seizures		
Dementia		
Apnea		
Esophageal Structures		
Thyroid Issues		
Scoliosis		
Bronchitis		
Lung Fibrosis		
Asthma		
Shortness of Breath		
CHF		
Angina		
Tachycardia		
High Blood Pressure		
Kidney Disease		
Kidney Stones		
Liver Disease		
Fatty Liver		
Hepatitis		
Ulcers		
Acid Reflux/GERD		

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Constipation		
Dysmenorrhea		
Hysterectomy		
Ovarian Cyst		
Uterine Fibroids		
Enlarged Prostate		
Frequent UTI		
Hemorrhoids		
Incontinence		
Diarrhea		
Anemia		
Diabetes		
Syncope		
Muscle/Mobility		
Rheumatoid Arthritis		
Joint Pains		
Cancer		
Autoimmune Disorder		
Long COVID		
Insomnia		
Parkinson's		
Cerebral Palsy		
Anxiety		
Depression		
Obsessive/Compulsive		
Sensory Processing		
Mental Health		

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List of Current Medications

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List all pills, capsules, tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion. If you have more than 14 medications, make a copy of this form.

Medication (Brand and Generic Name)	**Dose**	**How and How Often You Take the Medication**	**Reason for taking**	**Date Started**	**Prescriber**

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MEDICAL HISTORY

Emergency Contact Information: _____

Primary Care Physician: _____

Address: _____

Contact Information: _____

Dentist: _____

Address: _____

Contact Information: _____

Last Physical Exam: _____ Last Dental Exam: _____

Do you see other Doctors (Specialists)? _____

_____

_____

_____

Are you allergic to any medication or food:

_____ _____

_____ _____

_____ _____

Do you have any Special Dietary Restrictions:

_____

_____

_____

Are you working on a particular aspect of your health (weight loss, blood pressure, etc.):

_____

_____

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Some conditions can run in families, are any of these disorders in your family?

Hypertension	Diabetes	Arthritis
Stroke	Gout	Epilepsy
Heart attack	Cancer	Other: _____
Kidney disease	Intellectual Disability	Other: _____

Current Height: _____ Current Weight: _____

Have you had any surgeries:

_____

_____

_____

Is there something unexpected in your history (born with one kidney, esophageal stricture, etc.):

_____

_____

_____

Who helps you make difficult medical decisions? _____

Do you have a DNR Order? _____ Or a Durable Power of Attorney? _____

If you do, please attach a copy to your application.

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DISABILITIES SERVICES

If you are currently receiving services for an intellectual or developmental disability, please provide us with some information. If you have a copy of your plan or any assessments, those are very helpful to us in this process.

Services from the Local IDD Authority or a Private Provider

- o General Revenue
- o STAR + Waiver
- o Intermediate Care Facilities
- o Texas Home Living
- o CLASS
- o Home and Community Based Services

If you're unsure how your services are structured, check any that apply:

- o Service Coordinator/Case Manager visits you
- o Personal Attendant Services or Respite
- o Attends a Day Habilitation Program
- o Receives Foster Care/Host Home Services
- o Resides in a group home

Can you tell us who is in charge of the services you now receive?

Contact Name: _____ Phone #: _____

Address: _____

Email Address:_____ Agency: _____

One of the services you may have received from your Local IDD Authority is behavior management. Would you tell us about your experience?

_____

_____

_____

_____

EVALUATIONS

Professional evaluations and assessments can help us determine the best course of action. Have you had any?

- o Psychological
- o Counseling
- o Psychiatric
- o Behavioral Health Hospitalization
- o Speech-Language
- o Medical (Physical)

We would really like to have a copy of your most recent evaluations. Please fill out and sign the Consent Form attached to this application, and we will take care of getting the evaluation from your providers.

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PREVIOUS EXPERIENCES

As we travel through life, we often live in different places and different situations. People attend different programs that are helpful, fun, or both. We may move for convenience or for necessity. Please tell us about the places you've lived and the places you've attended. Help us understand why you were there and what caused you to move on to your next adventure. Often these are called "schools", "group homes", "workshops", or "health facilities", but maybe named something else entirely. *If you need to copy this page to include more, that's fine.*

Place: _____ Dates: _____

Address: _____

Contact Person: _____ Title: _____

Email: _____ Phone: _____

What sort of place is this? _____

Why did you move on? _____

Place: _____ Dates: _____

Address: _____

Contact Person: _____ Title: _____

Email: _____ Phone: _____

What sort of place is this? _____

Why did you move on? _____

Place: _____ Dates: _____

Address: _____

Contact Person: _____ Title: _____

Email: _____ Phone: _____

What sort of place is this? _____

Why did you move on? _____

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Request for Release of Information

Applicant Name: _____ Birth date: _____

I, the undersigned, certify that I am the applicant for placement, or the legal guardian of the applicant named above, and I authorize Breckenridge Village to obtain the following pieces of information to determine suitability of placement.

This consent covers all records, regarding the identity, history, evaluations, or treatment for the applicant named above including the following records:

Information being share include the following records:

Psychological evaluations
Psychiatric evaluations
Psychological/social history
Medical tests results and diagnosis
Immunizations
Prescription records
Medical records/history
Previous placement information
Previous Incident Reports
Previous Treatment/Service plans
Discharge summary
Hospitalization information
Special education reports
Counseling Reports
Speech/Language Evaluation
Physical examinations
Other: _____

Information that is most useful is usually less than five years old, but older material may be needed for perspective or explanation.

All information will be held in strictest confidence and used solely for the purpose of determining suitability for placement in a Breckenridge Village Program. If admission is denied all material will be returned or destroyed. Only a summary will be maintained for future reference.

Consent is subject to revocation at any time. If consent is withdrawn, all material will be returned or destroyed. This authorization is valid for 12 months from the date of signing.

_____ _____
Signature: Applicant Date

_____ _____
Signature: Guardian/Advocate Date