APPLICATION FOR ADMISSION / Able Training Center

Name: ____ Date of Birth: ___________
first middle last

Address: ____ Age: ____________

____ Sex: ____________

Phone #: _____________________________________

Race: ____________________________ Religious Affiliation: ________________________

SSN: ____________________________ Referred By: ________________________________

Name of Parent/Guardian: ____

Address: _______________ ___________________________

____

Phone #: ____

Does anyone have legal guardianship of individual?: ___yes ____no

If yes, name of legal guardian: ____________________________________

Name of Supports Coordination Organization: ____

Name of Supports Coordinator: ____

Address: ____

____

Phone #: ____

BSU Number: ________________________

Funding Source for Day Programming: ___________________________________

Approved Staffing Ratio for Day Program: ___________________

Name of Primary Care Physician: ____

Address: ____

____

Phone #: ____

Emergency Contact: _______________________________________

Relationship to Individual: __________________________________

Phone #: ____

Able-Services, Inc. is a charitable 501(c)(3) organization as provided by Internal Revenue Service requirements. The official registration and financial information of Able-Services, Inc. may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1 (800) 732-0999. Registration does not imply endorsement. This institution is an equal opportunity provider and employer.

Medical Information

Level of Intellectual Functioning: ____

Diagnosis: ____

____

Date of Most Recent Physical Examination: ___________________

(If considered for admission, a current physical (within 1 year) will be required. It must include all up to date immunization records (Diptheria/Tetanus within 10 years), a Tuberculin Test (within 2 years), and a statement that person is free of communicable diseases.)

Insurance Name: ____________________________ Policy #: _________________________

Medicare Number: _________________________________

Current Medications: – Include any occasionally used medication like Tylenol

Medication Name	Dosage	Time of Administration

Allergies (to drugs, food, other): ____

Special Diet (describe): ____

Adaptive Aids or Equipment: (please describe if yes)

Hearing Yes ____ No _____ ____

Vision Yes ____ No _____ ____

Mobility Yes ____ No _____ ____

Describe Needs for Support Related to the Following:

Toileting: ____

Eating: ____

Communication Skills – Expressive and Comprehension (include example of verbalizations, tools/methods of communicating, language(s) spoken): _________________________________

____

Educational Information

High School Name: ________________________________ Date of Graduation: __________

Describe Curriculum: ____

List Individual's Interests, Hobbies, Leisure Activities: _________________________________

____

____

Current Programming

Name of Current Day Program: ____

Date of Admission: ____________________

Describe Current Program Goals/Skill Development: ______________________________________

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____

What do you like about your current program? ____________________________________

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____

What do you dislike about your current program? __________________________________

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Why are you interested in coming to Able-Services' Day Program? _____________________

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It is the policy of Leg Up Farm/Able-Services that we are a smoke free facility. Smoking anywhere on the premises – indoors or outdoors – is strictly forbidden. This includes the use of vaping systems and electronic cigarettes. By submitting this application to be considered for admission, I understand that I will not be able to smoke ***at any time*** while in day programming at Able-Services. Please initial/check the box below acknowledging you understand and agree to this policy.

☐ By initialing/checking this box I certify that I understand the No Smoking Policy Able-Services and agree to abide by this rule as a condition of my admission to the program, if I am accepted.

☐ By initialing/checking this box, I certify that the information contained in this application is true and accurate to the best of my knowledge.

____

Printed Name of Person Completing This Application

____ ________________

Signature of Person Completing This Application Date

***See List on Reverse of Additional Documentation Needed for Admission**

Other Documentation Needed:

- Physical/Immunizations/TB Test/Communicable Disease Statement (Physical Form)
- Copy of Dr.'s prescription for all medication that will be taken during program hours (including over the counter medications)
- Medical/Developmental History (Lifetime Medical Report)
- Status of Self-Medication Form
- Current Psychiatric Evaluation, Psychological Evaluation, or IEP
- Copy of Insurance Card(s)
- Copy of Social Security Card
- Copy of Individual Service Plan
- Legal Guardianship Documentation (if applicable)