Dove Pointe, Inc. & Residential Services
Program Application

Mission Statement:

It is our mission to connect individuals and supports to meet desired outcomes, interests, and needs. Whether interested in vocational, residential, medical, therapeutic or children's services, the professional and experienced staff at Dove Pointe is available to be of service to you and your family.

Prior to admission the following information must be completed and submitted to Dove Pointe's Admission Coordinator.

Application Date: ______________
Anticipated Start Date: __________

Section 1-Demographic Information

Applicants Name: ____
(Last) (First) (Middle)

Current Address: ____
(Street) (City) (County) (State) (Zip)

Phone: _________________

DOB: _________ Sex: ____ Race: ____ SS#: ______________

Disability: _____________ Medicare #: _____________ MA #: ______________

Who does the individual reside with:

____Parents ____Mother ____Father ____Relative ____Agency ____Foster Care

Primary Caregiver's Name: _______________________ Phone: ____________________

Address if different from above: ____
(Street) (City) (State) (Zip)

If applicable:

Legal Guardian Name: __________________________ Phone: _____________________

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

Surrogate Decision Maker: _______________________Phone: _____________________

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

Revised 6-13-16

Please list any other family members living in the home and their relationship:

Name: ____________________________ Relationship: ___________________________
Name: ____________________________ Relationship: ___________________________
Name: ____________________________ Relationship: ___________________________

Emergency Contacts:

Name: _____________________ Address: ____
Home Phone: ______________ Cell: ______________ Relationship: ____________

Name: _____________________ Address: ____
Home Phone: ______________ Cell: ______________ Relationship: ____________

Where does the individual go during the day:

(School/Day Program/Work): __________________________
Address: ____
Contact Person: _______________ Phone: ______________

Please list any other Providers/Agencies involved:

Name of Program	Contact Person	Telephone Number
____________________	___________________	_________________
____________________	___________________	_________________
____________________	___________________	_________________

Section 2- Funding

Is the individual funded: Yes: ____ No: ____
If no, please state why: ____
If yes, please select funding type: (Please check one)

___ Adult Medical Day
___TBI Waiver-Day
___TBI Waiver- Residential
___FPS-Day
___FPS-Residential
___Other-Please describe: _______________________________
Name of Waiver: _______________________________________
Effective Date of Enrollment in Waiver: ___________________

Section 3- Transportation

Is transportation needed for the individual? Yes: ____ No: ____
If yes, does the individual utilize a wheelchair? Yes: ____ No: ____
Please indicate any special accommodations that may be required:
____
____.

Section 4- Residential Services Only: Dove Pointe requires that Rep-Payee responsibility is transferred to Dove Pointe Residential Services, Inc. as part of the admissions process.

_____________________________________ _________________
Signature of Applicant/Parent/Guardian **Date**

Section 5- Other Information

Does the individual receive Food Stamps? Yes: ____ No: ____
If yes, what County? _________________ Food Stamp ID#: __________________
Identification Card provided? Yes: ____ No: ____
Birth Certificate provided? Yes: ____ No: ____

Section 6 - Application Information

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

_____ communicates in sentences _____ uses sign language _____ understands some commands
_____ uses some words _____ uses a communication device _____ does not understand commands
_____ does not use words _____ understands most commands

Comments:
____
____
____.

Eating Habits: (Check those that apply and explain, if necessary.)

_____ independent _____ assistance with preparation
_____ dependent _____ needs assistance eating
_____ needs supervision for:
____.

Bathing/Hygiene: (Insert “I” for independent, “S” for supervised, “D” for dependent, or “N/A” for each)
_____ prefers bath or shower _____ shaving _____assistance in/out of tub
_____ menstrual needs _____ dressing _____ tooth brushing
_____ hair care

Comments:
____
____.

Toileting: (Check those that apply and explain, if necessary.)
_____ continent _____ incontinent
_____ stress incontinence _____ night time incontinence
_____ frequent UTI uses Depends: _____ at all times _____ night time only _____at nap

Comments:
____
____.

Sleep Habits:
Does individual have a bedtime? _____ What time? ________________
Does individual take a nap? _____ What time? ________________
Does individual wake up during the night? _____
If so, what should be done? ____

Comments:
____
____.

Mobility: (Check any that are appropriate and comment, if necessary.)
_____ walks independently _____ wheelchair used sometimes _____ walker
_____ walks, but needs some assistance _____ wheelchair used at all times _____ cane
_____ climbs steps

If applicable, what assistance does the individual need in transferring?
____
____.

Comments:
____
____.

Personal Information:

Please list hobbies:
____

Is the individual social?
____

Does he/she like animals?
____

Does he/she have favorite TV shows or movies?
____

Does he/she smoke?
____

Are there any fears we should be aware of?
____

Please describe the individual's personality traits:
____
____.

Are there any behaviors a caregiver should be aware of?
____
____.

Is there a formal behavior plan that would need to be followed? If so, who developed the plan?
Yes: ______ No: ______ Developed by: __________________ Date of BIP: ____________

Section 5- Health/Medical Information

Diagnosis:
____
____.

Allergies (Food or Medications):
Allergy: ____________________________Reaction: ____________________________________
Allergy: ____________________________Reaction: ____________________________________
Allergy: ____________________________Reaction: ____________________________________

Current Weight: ____LBS.

Immunizations: (circle one) Yes (up to date) No

Hepatitis B Vaccine: Yes: ___ No: ___ Hepatitis B Carrier: Yes: ___ No: ___ Unknown: ___
PPD (TB testing): Yes: ___ No: ___ Positive/Negative (circle one)
MRSA Carrier: Yes: ___ No: ___

Last Date of Tetanus: __________________________

Does individual require assistance with taking medication?
_____ Yes _____ Self Administration _____ Needs prompting to take

Please check all that apply or explain to the best of your ability:

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 items
- □ Liquid form of medication
- □ Liquid form with thick it
- □ G-tube only, nothing by mouth
- □ Other:____________________ (Please specify)

Has the individual ever had a chocking incident? Yes: ___ No: ___
Hs the individual ever had pneumonia? Yes: ___ No: ___ Date: _______________

List Adaptive Equipment (Helmet, eating utensils, splints, AFO, Bi-pap)	**Time Adaptive Equipment is Used**
Example: Right Hand Splint	*Wears splint during sleep hours/bedtime*
_____________________________________	__________________________________
_____________________________________	__________________________________
_____________________________________	__________________________________

Seizures: Yes: ___ No: ___
Are seizures longer than 5 minutes? Yes: ___ No: ___

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 seizure for 30-45 minutes).

____
____
____

How long do seizures last?

____

How long after their seizure do they sleep?

____

During seizure are there any special procedures/medications to be given?

____
____

General Health – Please check only those that apply (To Be Detailed on Initial Assessment):

- □ 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?
- □ Any presents of old scars, bumps or lumps?
- □ 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, and no teeth)
- □ History of eye problems
- □ Use of corrective lenses (glasses)
- □ History of cataracts or glaucoma
- □ Abnormal sensitivity to noise
- □ History of ear infections
- □ Uses a hearing aide 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 or diarrhea (circle one or both)
- □ 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
- □ History of urinary tract infections

- ◻ Bed-wetting or incontinence
- ◻ History of fainting or loss of consciousness
- ◻ History of seizures or other nervous system problems
- ◻ 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
- ◻ 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
- ◻ Heat or cold intolerance
- ◻ Increased thirst
- ◻ Unexplained changes in weight (increase or decrease)

Signature Section

Signature of applicant: ____Date:______________________

Signature of person completing form: ______________________________Date: _____________________

Signature of legal guardian (if applicable): ___________________________Date:_____________________

DOVE POINTE
PRE-ADMISSION PAPERWORK
(Required prior to admission)

These documents and information are necessary prior to the start of support services at Dove Pointe. Please provide us with as much information as you can.

____ Authorization/consent for medical information
____ Recent physical assessment form completed/signed by primary care physician
____ Allergies
____ List of medications
____ PPD date and results
____ MOLST form completed by individual or family and signed by physician
____ Copy of Immunization record
____ PMOF (Medication order form) filled out and signed by primary care physician
____ Copy of Social Security card
____ Copy of Birth Certificate
____ Copy of State issued picture ID
____ Signed W-4 tax form
____ Signed 507 tax form
____ Signed I-9 form
____ Copy of Insurance card
____ Signed Media and Photo Release Form
____ Signed Meal Benefit Form
____ Copy of Guardianship paperwork/Durable Power of Attorney
____ Emergency Contact numbers for:
____ Legal guardian or next of kin
____ Secondary emergency number
____ Physician
____ Dentist
____ Eye Doctor
____ Podiatrist
____ Neurologist
____ Psychiatrist
____ Psychologist

Additional paperwork for **Adult Medical Day Care Waiver individuals**
____ AERS assessment
____ Freedom of Choice Consent
____ ADCAPS
____ 257
____ Funding Authorization

Nurse to complete the below during the admission process
____ Completed initial assessment
____ Reviewed medications
____ Individual medication education
____ Nursing Care Plans