3/21/21

PEER PLACE AT FBCH

APPLICATION FOR ADMISSION

Date _____ Applicant's SS # _____ Male _____ Female _____

_____ _____ _____
Applicant's Full Name | Preferred Name | Date of Birth

_____ _____ _____
Applicant's Street Address | City, State and Zip Code | Phone

_____ _____ _____
Applicant's Mother | Applicant's Father | Parent Having Custody

_____ _____
Parent's address (if different) | Phone

_____ _____
Non-Custodial parent's address (if different and applicable) | Phone

_____ _____
Custodial Parent/Guardian e-mail | Names and ages of Applicant's siblings

Applicant's legal competency status: _____
(Adults are considered legally competent unless a court has found otherwise and appointed a conservator)

Applicant's source of financial support: (check all that apply): Parents ___ Insurance _____
Social Security _____ VA benefits ___ Employment _____ Other ___

Days of Service you are applying for: (please circle): Monday, Tuesday, Wednesday, Thursday
(Subject to teacher availability and class size limitations)

Name of the person/agency that referred you to Peer Place: _____

Disability (if multiple disabilities, please list all): _____

_____

Applicant's Prior Experiences

Please check all situations in which the applicant has participated, and complete the following information on each situation:

_____Day School or Program
_____Sheltered Workshop
_____Group/Family Care Home
_____Independent Living Situation
_____Competitive Employment
_____State/Public School
_____Private School
_____Other (explain) _____

1. _____ _____
Name of school/facility/program (refer to list above) Dates (from/to)

_____
Address (City/State/Zip)

_____
Reason or Explanation for leaving

Do you give consent for Peer Place to contact them about applicant? (Please circle) YES NO

_____
Name and telephone # of person to contact for information about applicant

2. _____ _____
Name of school/facility/program (refer to list above) Dates (from/to)

_____
Address (City/State/Zip)

_____
Reason or Explanation for leaving

Do you give consent for Peer Place to contact them about applicant? (Please circle) YES NO

_____
Name and telephone # of person to contact for information about applicant
(use additional sheets if necessary and attach to application)

Has applicant ever had any of the following? If yes, please give name of the professional/school/facility involved in the testing and include copies of any reports with this application.

	Yes	No	Date(s)	Where
Psychological Evaluation	____	____	_____	_____
Psychological Counseling	____	____	_____	_____
Psychiatric Evaluation	____	____	_____	_____
Psychiatric Therapy	____	____	_____	_____
Psychiatric Hospitalization	____	____	_____	_____
Speech/Language Assessment	____	____	_____	_____
Medical Evaluation	____	____	_____	_____
Other_____	____	____	_____	_____

Additional Comments if any: _____

General Questions About the Applicant

(Attach additional sheets, as needed. The more information you give us, the better Peer Place can design a more effective Individual Program Plan for the participant.)

1. Please describe applicant's general health, including special medical problems and/or physical disabilities:

2. Please describe applicant's communication abilities:

3. Please describe applicant's communication weaknesses:

4. Please describe applicant's social/emotional state most of the time (for example: withdrawn, hyperactive, frustrated, sociable, even-tempered, moody, etc.)

5. Please describe applicant's self-help skills and needs and what Peer Place can do to help with these.

6. Please describe the applicant's daily routine and leisure activities.

7. Please describe the applicant's functional disabilities, as you perceive them.

8. Does the applicant have self-awareness of his/her own disability and, if so, please describe how he/she feels about it?

9. Please describe the applicant's specific aptitudes, interests and strengths.

10. Please describe applicant's self-stimulatory behaviors, if any, the frequency per day and how the parent/guardian handles the behavior(s).

11. Please describe any activities, subjects, situations or circumstances that applicant strongly dislikes and/or fears.

12. Please describe your goals and expectations for the applicant with Peer Place and what you hope can be accomplished.

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

	Yes	No
Tobacco use	_____	_____
Illegal drug use	_____	_____
Alcohol use	_____	_____
Criminal activity	_____	_____
Sexual misconduct	_____	_____
Physical abuse of self	_____	_____
Physical abuse of others	_____	_____
Verbal abuse of others	_____	_____

_____

14. Has there ever been an accusation of the applicant engaging in criminal activity, including but not limited to theft, assault, sexual misconduct, sexual assault, or sexual harassment?
Yes _____ No _____. If yes, please explain.

_____
_____
_____
_____

PLEASE LIST 3 PEOPLE WHO HAVE WORKED WITH OR KNOW THE APPLICANT CLOSELY, EACH OF WHOM YOU GIVE CONSENT TO PEER Place TO TALK TO ABOUT APPLICANT:

1_____ _____
Name Title or Position

_____ _____
Phone Email address

2_____ _____
Name Title or Position

_____ _____
Phone Email address

3_____ _____
Name Title or Position

_____ _____
Phone Email address

Medical and Prescription Drug Information

Information must be completed by the parent or legal guardian for the applicant as part of the Application for Admission. Please print. If answer is "no" or "none" please indicate.

_____ _____
Name of Applicant Date of Birth

_____ _____
Home Address of Applicant Phone

_____
Primary Physician, name, address and Phone number

Names of physician specialists who have treated Applicant:

1._____ Phone: _____

2._____ Phone: _____

3._____ Phone: _____

Please list the prescription medications the Applicant is currently taking on a frequent basis:

Prescription Name	Dosage/Frequency	Prescribed by	Date Initially Prescribed
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

(add additional pages to Application if necessary)

Please list medications/dosage the Applicant has taken in the last six months but is not now currently taking:

1._____	_____	_____	_____
2._____	_____	_____	_____

Notice: The staff and volunteers of Peer Place DO NOT administer medication, either prescription or over-the-counter, at any time. We gather this information for our records.

Allergies

Is the applicant allergic to any medications? Yes_____ No_____. If Yes, please list: _____

_____

Is the Applicant allergic to any foods, pollens, insect bites, or other allergens.? Yes_____ No _____

If yes, please list: _____

If the applicant is on any medication/injection for treatment of any allergens, please give name of medication, dosage and frequency: _____

_____

Health History

If the applicant is prone to (or has had) problems with any of the following conditions, please indicate "Yes", otherwise "No". Also, please list preferred treatment if applicable.

	Yes	No	Explanation
Sinus trouble	_____	_____	_____
Headaches	_____	_____	_____
Eyes	_____	_____	_____
Vision	_____	_____	_____
Ears	_____	_____	_____
Hearing	_____	_____	_____
Asthma	_____	_____	_____
Epilepsy	_____	_____	_____
Tuberculosis	_____	_____	_____
Heart trouble	_____	_____	_____
Kidney disease	_____	_____	_____
Stomach issues	_____	_____	_____
Diabetes	_____	_____	_____
Diarrhea	_____	_____	_____
Constipation	_____	_____	_____
Fainting spells	_____	_____	_____
Menstrual issues	_____	_____	_____
Muscle problems	_____	_____	_____
Neurological issues	_____	_____	_____
Emotional problems	_____	_____	_____
Psychological issues	_____	_____	_____
Psychiatric issues	_____	_____	_____

Please list all surgeries, dates and attending physicians: _____

_____

_____

Has applicant ever had seizures? Yes_____ No_____. If yes, is he/she currently Experiencing them? Yes _____ No_____ and, if so, what type are the seizures and with what frequency? _____

If so, what is the medication and dosage? _____

Does applicant have diabetes: Yes_____No _____. If yes, please explain Applicant's diet restrictions and eating schedule: _____

_____

Does applicant take insulin? Yes _____ No _____. If yes, please provide shot regimen and/or dosage:

_____

Finally, please take the time to tell us if there are any other facts, conditions or circumstances that you know of, not heretofore listed or described, which would or might be a factor that Peer Place should consider in passing upon the merits of this application or that might otherwise influence the care, health and well being of the applicant while in the care of Peer Place if this application is accepted. Please print: _____

_____

_____

_____

_____

In conclusion, Peer Place reserves the right to require the applicant to produce, upon written request, copies of all legal documents that establish the undersigned's legal capacity to act for and on behalf of the above-named applicant, now or at any time in the future, with the expense thereof to be paid by the undersigned.

The attached "Peer Place REPORT OF PHYSICIAN" is to be completed by the applicant's primary care physician and returned to Peer Place with the application, or mailed to us at First Baptist Church Hendersonville, IO6 Bluegrass Commons Blvd., Hendersonville, TN 37O75

Signature

The undersigned affirms that I (or we, as the case may be) am the lawful legal representative of the applicant hereinabove named, as parent, guardian, conservator, or otherwise, as the case may be, having full care, custody and control of the person of the applicant, that all of the preceding information that I have provided is a complete and true statement of all the facts, circumstances and medical and health information relative to this applicant's application for enrollment in the services of Peer Place.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent/Guardian/Representative of Applicant Date

Application Approved: By: _____

For (Please circle) Monday/Tuesday/Wednesday; Thursday; First day: _____

_____ _____ _____

Name of Patient (PEER Place Applicant) Address DOB

PEER PLACE AT FBCH

REPORT OF PHYSICIAN

1. The following report of the patient is made by: Dr (print)_____
2. Are you duly licensed to practice medicine in Tennessee: Yes □ No □
3. Have you made a personal physical and mental examination of the patient? Yes □ No □
4. What is the medical history of the patient? _____

_____

_____

_____

_____

5. What is the nature and extent of his/her intellectual or developmental disability or disabilities?

_____

_____

_____

_____

_____

6. Please indicate your evaluation of the patient by checking one in each of the following areas:

	Excellent	Good	Fair	Poor	Chronic	N/A
Mental Condition	□	□	□	□	□	□
Physical Condition	□	□	□	□	□	□
Social Condition	□	□	□	□	□	□
Educational Condition	□	□	□	□	□	□
Adaptive Behavior	□	□	□	□	□	□
Social Skills	□	□	□	□	□	□
Impact of current living Conditions on his/her disability	□	□	□	□	□	□

Please make additional comments you deem appropriate about any of the above responses:

_____

_____

_____

_____

_____

7. Is the patient currently taking any medication? Yes □ No □
8. If "Yes" to question 7, please list each medication and the usual dosage:

_____

_____

_____

_____

9. Please indicate how the above listed medication of the patient will affect the following by checking the appropriate response in each category:

	No Affect	Will Affect	Will Impair	Cannot Determine
Mental Condition	□	□	□	□
Physical Condition	□	□	□	□
Educational Behavior	□	□	□	□
Adaptive Behavior	□	□	□	□
Social Skills	□	□	□	□

10. Immunizations:

	Date
Measles	_____
Mumps	_____
Rubella	_____
Tetanus/Diptheria	_____
Tetanus Booster	_____
Polio (indicate OPV or IPV)	_____
Hepatitis B	_____ suggested but not required for enrollment

11. Please list all allergies: _____
    Does patient have a history of seizures: Yes □ No □ If Yes, please explain at ¶13 below.

12. PEER Place is a service organization that provides persons with intellectual or developmental differences the opportunity to learn, in a day group setting, new life skills in an out-of-residence environment. Please describe any medical restrictions imposed on the patient that PEER Place should be aware of, such as, by example but not by limitation, lifting, running, light to moderate exercise, light intolerance, noise intolerance, claustrophobia or other phobias, etc: _____
    _____
    _____

13. Other or additional comments: _____
    _____
    _____
    _____
    _____
    _____
    _____

Physician signature: _____ Date: _____
Address:

_____
_____
_____
Telephone: _____