CENTER ON DEAFNESS

3444 Dundee Road Northbrook IL 60062 ~ 847/559-0110 TTY 847/559-9493 FAX 847/559-8199

APPLICATION FOR ADULT PROGRAMS

IDENTIFYING INFORMATION

Date: _____

Name: _____
LAST FIRST MIDDLE

Address: _____

City: _____ State: _____

Zip: _____ Country: _____

Phone: _____ Sex: ☐ F ☐ M

Birthdate: ___/___/___ Age: _____

Race: _____

PLEASE PROVIDE PHOTO

Religion: _____ S.S.#: _____

Marital Status: _____ Military Service: _____

Medicaid #: _____ Medicare #: _____

Private Insurance: _____

Primary Language/method of communication: _____

Source of Referral: _____

_____

_____

PARENT/GUARDIAN INFORMATION (CUSTODY/GUARDIANSHIP STATUS)

☐ Self ☐ Mother ☐ Father ☐ DCFS ☐ G&A ☐ Other _____

☐ PARENT ☐ GUARDIAN NAME: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

EMERGENCY CONTACTS:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

REASON FOR REFERRAL AT THIS TIME

Describe and discuss behaviors or conditions that are creating significant problems in the applicant's daily functioning and psychosocial adjustment (for more room on any item, please use back of page.)

_____

_____

_____

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_____

PERSONAL AND FAMILY HISTORY

Please describe the applicant's developmental/childhood/prior history and age at which emotional/behavioral problems were first identified.

List names and ages of parents, stepparents, and siblings. If any members of the immediate family are deceased, indicate the month and year of death. If there has been a divorce, an adoption, and/or re-marriage, please explain.

If there were any major events in the applicant's life that disrupted the relationship with parenting figures, please explain.

PERSONAL AND FAMILY HISTORY (CONTINUED)

Describe the applicant's home and community environment/circumstances. Include information on usual peers and any religious/cultural group involvement.

Hobbies, personal interests, involvement in play/recreational activities.

Indicate any significant familial medical or mental health problems.

Describe the applicant's typical daily activities/schedule.

Describe how family plans to be involved in applicant's treatment program (include siblings).

VOCATIONAL EXPERIENCE

In chronological order, list below all the places of competitive or workshop employment.

Employer: _____

Type of Work: _____

Length of Employment: _____ Wage Earned: _____ Hours Per Week: _____

Reason for Leaving: _____

_____

Employer: _____

Type of Work: _____

Length of Employment: _____ Wage Earned: _____ Hours Per Week: _____

Reason for Leaving: _____

_____

Employer: _____

Type of Work: _____

Length of Employment: _____ Wage Earned: _____ Hours Per Week: _____

Reason for Leaving: _____

_____

Employer: _____

Type of Work: _____

Length of Employment: _____ Wage Earned: _____ Hours Per Week: _____

Reason for Leaving: _____

_____

VOCATIONAL EXPERIENCE (CONTINUED)

List the name and telephone number of the last supervisory in charge of evaluating the applicant's work and behavior on the job.

Supervisor's Name: _____ Phone #: _____

Has the applicant ever been a client of Vocational Rehabilitation (ORS in Illinois): ☐ Y ☐ N

If YES, Counselor's name: _____ Date applicant was a client of ORS: _____

Address of office: _____ Phone #: _____

LANGUAGE AND COMMUNICATION

Does the applicant rely on speech (lip-reading)? ☐ Yes ☐ No

If YES, rank the applicant's proficiency: ☐ Fair ☐ Good ☐ Excellent

Does the applicant use sign language? ☐ Yes ☐ No

If YES, please check which aspect of sign language is most representative:

- ☐ Fluent in American Sign Language
- ☐ Comfortable with conversation sign language
- ☐ Knows basic words and letter

Does the applicant communicate using voice? ☐ Yes ☐ No

If "Yes", describe effectiveness/problems with voice communication:

_____

_____

_____

_____

_____

LANGUAGE AND COMMUNICATION (CONTINUED)

Comments on applicant's preferred mode of communication: _____

Comments on applicant's acceptance of their hearing impairment: _____

Comments on other communication/language issues: _____

HISTORY OF MENTAL HEALTH TREATMENT

List, in chronological order, all inpatient and outpatient psychiatric treatment/counseling with diagnosis, previous placements, or participation in related community programs (if more space is needed, use the back of this page)

_____

_____

_____

_____

_____

_____

Date of most recent PSYCHIATRIC evaluation: _____
(please attach a copy)

Date of most recent PSYCHOLOGICAL evaluation: _____
(please attach a copy)

PRESENT LEVEL OF ADAPTIVE FUNCTIONING

(Communication, Daily Living/Community, Interpersonal, Motor Skills)

Describe applicant's strengths in these areas. (Please attach results of any adaptive functioning assessment administered to the applicant such as the Vineland Adaptive Behavior Scale, ICAP, SLOF, or other)

_____

_____

_____

_____

Describe applicant's weaknesses in above functioning areas: _____

_____

_____

_____

PRESENT LEVEL OF ADAPTIVE FUNCTIONING (CONTINUED)

Applicant's relationship with family members: _____

Applicant's relationship with peers; adults: _____

Applicant's attitude toward school/work: _____

HISTORY OF SUBSTANCE ABUSE/OTHER ABUSE/ENDANGERING BEHAVIOR

Has the applicant ever displayed injurious/violent behavior toward himself or others? Ever attempted suicide? Damaged property while acting out? Such incidents must be reported. Please indicate below, listing occurrences by date, and describe the particular behavior(s) and circumstances surrounding each incident.

_____

_____

_____

_____

Has applicant ever been involved in an abuse or neglect situation? ☐ YES ☐ NO

If YES, what type(s) of abuse and what was the type(s) of involvement? (Check all that apply)

☐ **Emotional abuse:**	☐ *Victim*	☐ *Perpetrator*	☐ *Witness*
☐ **Physical abuse:**	☐ *Victim*	☐ *Perpetrator*	☐ *Witness*
☐ **Sexual abuse:**	☐ *Victim*	☐ *Perpetrator*	☐ *Witness*
☐ **Neglect:**	☐ *Victim*	☐ *Perpetrator*	☐ *Witness*

Please list abuse or neglect incidents by date and describe: _____

_____

_____

_____

Does this applicant or a family member have a history or is currently suffering from alcohol or chemical dependency. If so, please describe:

_____

_____

_____

_____

LEGAL STATUS/COURT ORDERS/PROBATION

If the client is on court ordered probation, please complete the information below:

Probation Officer: _____ Phone #: _____

Address: _____

City: _____ Zip: _____

Reason for probation: _____

_____

_____

_____

_____

When does probation end? _____

_____

Are there any other legal issues or court orders of which our staff should be aware? (Custody, pending court orders, guardianship issues, lawsuits)

_____

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_____

PHYSICAL EXAMINATION/HEALTH INFORMATION

(if available)

Date of last complete physical exam: _____ **(please attach a copy)**

Please list any allergies (if any): _____

_____

Other Medical Exam Dates	Results of Exams
Electrocardiogram (EKG): _____	_____
Neurological: _____	_____
Electroencephalogram (EEG): _____	_____
CT/MRI Scan: _____	_____

CURRENT MEDICATIONS

(if more space is needed, use the back of this page):

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

PHYSICAL EXAMINATION/HEALTH INFORMATION (CONTINUED)

Cause of hearing impairment: _____ Age of onset:_____

Does the applicant use a hearing aid? ☐ Yes ☐ No

Date of last audiological exam: _____

Does the applicant use cochlear implant? ☐ Yes ☐ No

Does the applicant use glasses? ☐ Yes ☐ No

Date of last vision exam: _____

Is the client ambulatory? ☐ Yes ☐ No

If NO, please explain: _____

_____

ADDITIONAL RELEVANT MEDICAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

INSURANCE INFORMATION

(Private Insurance, Medicaid, Medicare)

Is this applicant covered by private health insurance? ☐ Yes ☐ No

If YES, please complete the information below:

Company: _____ Type of coverage? ☐ Individual ☐ Family

Policy #: _____ Company's phone #: _____

Name of insured:_____ Insurer's Social Security #:_____

Does the applicant currently have Medicaid? ☐ Yes ☐ No

If YES, please write Medicaid number: #_____

Does the applicant currently have Medicare? ☐ Yes ☐ No

If YES, please write Medicare number: #_____

OTHER BENEFITS INFORMATION

Check YES or NO fear each benefit. If the applicant is receiving the benefit, relay the amount in the right column.

Does the applicant receive…		Benefit amount?
Social Security benefits?	☐ YES ☐ NO	_____
Food Stamps/Illinois LINK?	☐ YES ☐ NO	_____
Subsidized Housing (Sect. 8)?	☐ YES ☐ NO	_____
Income Entitlements?	☐ YES ☐ NO	_____

Referring Agent/Person (please print): _____

SIGNATURE OF PERSON COMPLETING THIS APPLICATION

NAME _____ RELATIONSHIP _____

PHONE NUMBER _____ EMAIL ADDRESS _____

****

Please remember to attach the following documents if available:

- ☐ 1. Medical and psychiatric history including immunization records
- ☐ 2. TB Screening
- ☐ 3. Identifying documents including:
  a. Birth certificate
  b. Copy of social security card
  c. Copy of hospitalization card or Medicare/Medicaid card
- ☐ 4. Photo (11/2 X 11/2)

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When completed, please mail this document and attachments to:

Adult Program Admissions
Center On Deafness
3444 Dundee Rd
Northbrook, IL 60062