FOR OFFICE USE ONLY:	
Date Completed App Received by CR	
Scheduled Review Date	

CORNERSTONE RANCH PROGRAM APPLICATION

Please complete application in full and return with $50 application fee and recent photograph of applicant. Incomplete applications will not be accepted.

I AM APPLYING FOR:	
☐ Residential Program	☐ Day Program
Requested placement date:	

APPLICANT INFORMATION			
Name:			
Preferred Nickname:			
Birthdate: / /	SSN: - -	Phone:	
Current Address:			
City:		State:	Zip:
Height:	Weight:	Gender: ☐ Male ☐ Female	
Marital Status:	Work/ Volunteer Experience:		

FAMILY INFORMATION/ EMERGENCY CONTACTS		
Mother’s Name:		
Home Address:		
City:	State:	Zip:
Preferred Email:		
Occupation/Company Name:		
Home Phone:	Cell:	Work:

Father's Name:		
Home Address:		
City:	State:	Zip:
Preferred Email:		
Occupation/Company Name:		
Home Phone:	Cell:	Work:

Legal Guardian Name (if other than parent):		
Home Address:		
City:	State:	Zip:
Preferred Email:		
Occupation/Company Name:		
Home Phone:	Cell:	Work:

EMERGENCY INFORMATION/ MEDICAL INSURANCE COVERAGE

Who would you like to be the first person contacted in the event of an emergency?		
Additional Emergency Contact (in addition to parent/guardian):		
Home Phone:	Cell:	Work:

In the event of a transfer (if given an option) is there a hospital preference? If so, which hospital?

Insurance Company:	Policy Number:	Group Number:
Insurance Company Address:		

SOCIAL SKILLS EVALUATION

EVALUATIONS & ASSESSMENTS			
Has the applicant had any of the following? If yes, give name of the person or agency. Include copies of reports from this person/ agency.			
Psychological Evaluation	☐ Yes ☐ No	Dates	Person/ Agency
Psychological Counseling	☐ Yes ☐ No	Dates	Person/ Agency
Psychiatric Evaluation	☐ Yes ☐ No	Dates	Person/ Agency
Psychiatric Hospitalization	☐ Yes ☐ No	Dates	Person/ Agency
Speech/ Language Assessment	☐ Yes ☐ No	Dates	Person/ Agency
Medical Evaluation	☐ Yes ☐ No	Dates	Person/ Agency
Occupational Therapy/ Physical Therapy	☐ Yes ☐ No	Dates	Person/ Agency

QUESTIONS ABOUT THE APPLICANT (please attach additional pages if necessary)
Describe the applicant's general health, including special medical problems, diagnosis and/or disabilities.
Describe the applicant's social/emotional state **most** of the time (For example: withdrawn, hyper-verbal, frustrated, sociable, even-tempered, etc.)
Does he/she prefer to be with peers, family, someone older, or alone? Please explain:
What does a typical day/ week look like for the applicant? What does free time look like?

PLEASE CHECK WHICH OF THE FOLLOWING APPLIES TO THE APPLICANT:

☐ likes people
☐ gets along well with friends
☐ follows directions willingly
☐ shows concern for others
☐ tends to be a loner
☐ respects rights & property of others
☐ gets angry easily
☐ tends to be shy initially
☐ Sensitive to light
☐ sensitive to touch
☐ sensitive to sound
☐ can get easily agitated/irritable
☐ gets anxious
☐ has self-stemming behaviors
☐ perseverates
☐ can introduce self
☐ forms close relationships
☐ is generally happy
☐ other: ____

Describe how the applicant reacts when he/she gets angry. (For example: pouts, tantrums, aggressive, etc.)

What techniques are used to de-escalate behaviors?

Does the applicant require constant at-home supervision? ☐ yes ☐ no
Can the applicant be left at home to function independently? ☐ yes ☐ no If yes, for what period of time? _________________
What type of supervision does the applicant require in the community?

What type of supervision does the applicant require in parking lots?

HAS THE APPLICANT EVER BEEN INVOLVED WITH THE FOLLOWING?

		If yes to any, please explain:
Tobacco	☐ yes ☐ no	
Drugs	☐ yes ☐ no	
Alcohol	☐ yes ☐ no	
Criminal Activity	☐ yes ☐ no	
Sexual Activity	☐ yes ☐ no	

WHICH OF THE FOLLOWING APPLY TO THE APPLICANT'S SPEECH/LANGUAGE AND COMMUNICATION SKILLS?

☐ speaks spontaneously
☐ can make wants and needs known
☐ uses complete sentences
☐ uses sign language
☐ has small vocabulary
☐ understands lengthy dialogue
☐ makes little or no effort to communicate verbally or with gestures
☐ understands short, direct commands
☐ communicates by writing
☐ comprehends written statements
☐ uses gestures effectively
☐ uses sentences effectively
☐ uses idiosyncratic gestures
☐ uses a communication device
If so, will they be bringing it? ☐ yes ☐ no

Describe the applicant's speech and language effectiveness:

SELF-HELP SKILLS

Will an attendant accompany the applicant? ☐ yes ☐ no
If so, what is their primary role?

MEALS	MOBILITY
☐ no assistance needed ☐ total assistance needed ☐ some assistance needed ☐ needs a straw for liquid ☐ food needs to be cut/chopped ☐ ability to prepare meals ☐ able to use microwave independently Special Instructions:	☐ walker ☐ braces ☐ crutches ☐ manual wheelchair ☐ electric wheelchair ☐ not able to stand for prolonged periods of time ☐ unsteady gate ☐ has physical limitations that limit participation in activities Special Instructions:

SHOWERS	DRESSING
☐ no assistance needed ☐ total assistance needed ☐ some assistance needed ☐ help shampooing hair only Special Instructions:	☐ no assistance needed ☐ total assistance needed ☐ some assistance needed ☐ needs help with buttons/zippers Special Instructions:

TOILETING	
☐ no assistance needed ☐ help transferring ☐ help cleaning up ☐ wets bed ☐ diapers/depends	Bowel Control ☐ full control ☐ limited control ☐ no control Bladder Control ☐ full control ☐ limited control ☐ no control Special Instructions:

OTHER SELF CARE			
washing face	☐ needs no help	☐ needs some help	☐ needs total help
brushing teeth	☐ needs no help	☐ needs some help	☐ needs total help
cleaning ears	☐ needs no help	☐ needs some help	☐ needs total help
combing hair	☐ needs no help	☐ needs some help	☐ needs total help
trimming fingernails	☐ needs no help	☐ needs some help	☐ needs total help
trimming toenails	☐ needs no help	☐ needs some help	☐ needs total help
using deodorant	☐ needs no help	☐ needs some help	☐ needs total help
shaving	☐ needs no help	☐ needs some help	☐ needs total help
managing menstrual period (if applicable)	☐ needs no help	☐ needs some help	☐ needs total help

I give permission for Cornerstone staff to directly assist with: ☐ Meals ☐ Mobility ☐ Showers ☐ Dressing ☐ Toileting ☐ Other Self Care I prefer for the staff to be: ☐ Male ☐ Female ☐ Either	**Signature:**

SCHOOLS OR PROGRAMS ATTENDED

Check all situations in which the applicant participated and complete the following information on each situation. Attach additional pages if needed.

☐ Public Education: Graduate: ________ Age: ________	☐ Independent Living
☐ State School	☐ Competitive Employment
☐ Private School	☐ Special Olympics
☐ Day School	☐ Other: ____
☐ Sheltered Workshop	☐ Church/ Spiritual Involvement:
☐ Group/ Family Care home	Desires: ____

Name of Facility:	Dates Attended:	
Address:	Phone:	
Type of Situation:		
Reason for Leaving:		
Person to contact for more information:	Phone:	E-mail:

Name of Facility:	Dates Attended:	
Address:	Phone:	
Type of Situation:		
Reason for Leaving:		
Person to contact for more information:	Phone:	E-mail:

Name of Facility:	Dates Attended:	
Address:	Phone:	
Type of Situation:		
Reason for Leaving:		
Person to contact for more information:	Phone:	E-mail:

I give permission for Cornerstone Ranch to contact any and all of the references, programs, schools, and professionals listed on this application.	**Signature:**

CONFIDENTIAL DOCUMENT

MEDICAL INFORMATION

APPLICANT NAME:____

DIAGNOSIS

Primary Diagnosis:	Secondary Diagnosis:
Any other medical diagnosis:	

PHYSICIANS & DENTIST

Name of applicant's primary physician:	
Address:	Phone:
Date of last physical exam:	
Name of applicant's dentist:	
Address:	Phone:
Date of last dental exam:	
List names of any other specialists who have treated or are treating the applicant:	

MEDICATIONS

Is the applicant on any regular medications or supplements? ☐ yes ☐ no

If yes, please list below: (please use an additional sheet if necessary)

Name:	Dosage/ Frequency:	Prescribed by:	Date Prescribed:
Name:	Dosage/ Frequency:	Prescribed by:	Date Prescribed:
Name:	Dosage/ Frequency:	Prescribed by:	Date Prescribed:
Name:	Dosage/ Frequency:	Prescribed by:	Date Prescribed:

Will any medications need to be administered during the day by Day Program staff? ☐ yes ☐ no

If so, please give instructions below and provide medication in original prescription bottle.

ALLERGIES & RESTRICTIONS

Is the applicant allergic to any medications? ☐ yes ☐ no

If yes, please list:

Does the applicant have any other allergies or sensitivities: foods, pollens, insect bites, etc? ☐ yes ☐ no
If yes, describe what allergies/ sensitivities, reactions, and what treatment is usually necessary

Does the applicant use an Epi Pen? ☐ yes ☐ no If so, one must be supplied by participant

Does applicant have any dietary restrictions? ☐ yes ☐ No
If so, please list:

FAMILY HISTORY

Since some conditions can be hereditary, or run in families, please provide the following information. If any member of the applicant's family has had any of the following conditions or problems, please indicate and identify their relationship to the applicant.

Hypertension	☐ yes ☐ no	Relationship:	**Stroke**	☐ yes ☐ no	Relationship:
Heart Attack	☐ yes ☐ no	Relationship:	**Kidney Disease**	☐ yes ☐ no	Relationship:
Diabetes	☐ yes ☐ no	Relationship:	**Gout**	☐ yes ☐ no	Relationship:
Cancer	☐ yes ☐ no	Relationship:	**Arthritis**	☐ yes ☐ no	Relationship:
Migraines	☐ yes ☐ no	Relationship:	**Glaucoma**	☐ yes ☐ no	Relationship:
Epilepsy	☐ yes ☐ no	Relationship:	**Other**	☐ yes ☐ no	Relationship:

HISTORY OF ILLNESS, HOSPITALIZATION, & SURGERY

Has applicant had more than a brief illness during the past three years? ☐ Yes ☐ No
If yes, when?
Please describe:

Name & address of attending physician:

Has applicant ever been hospitalized or had any surgery? ☐ Yes ☐ No
If yes, when?
Please describe:

Name & address of hospital:

HEALTH HISTORY

If the applicant is prone to (or has had) problems with any of the following, please check "Yes." If yes, explain in space provided. Also, list preferred treatment, if applicable. Please use an additional sheet if necessary.

Headaches	☐ Yes ☐ No	
Eyes	☐ Yes ☐ No	
Ears	☐ Yes ☐ No	
Hearing	☐ Yes ☐ No	
Scoliosis	☐ Yes ☐ No	
Chest Infections	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No	
Heart Trouble	☐ Yes ☐ No	
Kidney Disease	☐ Yes ☐ No	
Stomach Trouble	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Diarrhea or Constipation	☐ Yes ☐ No	
Fainting Spells	☐ Yes ☐ No	
Menstrual Problems	☐ Yes ☐ No	
Muscle Problems	☐ Yes ☐ No	
Neurological Problems	☐ Yes ☐ No	
Emotional Problems	☐ Yes ☐ No	
Psychological Problems	☐ Yes ☐ No	
Psychiatric Problems	☐ Yes ☐ No	
HIV	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

Please list all childhood diseases (mumps, measles, chickenpox, etc.):

IMMUNIZATION RECORD

Please check “yes” if applicant has been given a vaccination from each of the following diseases. If yes, please write date of last vaccination. If "no,” please leave date blank.

Measles	☐ Yes ☐ No	Date:	Must have been vaccinated with live vaccine since 1968.
Mumps	☐ Yes ☐ No	Date:	Must have had or been vaccinated with live vaccine after 12 months of age.
Rubella	☐ Yes ☐ No	Date:	Must have had or been vaccinated after 12 months of age.
Tetanus & Diphtheria	☐ Yes ☐ No	Date:	Series of 3 doses: 2nd dose 4-8 weeks after 1st dose; 3rd dose 6-12 months after 2nd dose
Tetanus Booster	☐ Yes ☐ No	Date:	Should be given every 10 years. Please give date of last booster.
Polio (indicate OPV or IPV)	☐ Yes ☐ No	Date:	Series of Trivalent Oral Polio (OPV) vaccine at 2, 4, & 18 months of age; or if taken 4 doses of Inactive Polio Vaccine, continue IPV every 5 years until 18 years old (list last 3 vaccinations)
Tuberculosis	☐ Yes ☐ No	Date:	Negative chest x-ray or Tine Test in past year
Hepatitis B	☐ Yes ☐ No	Date:	3 injections: 2nd dose 1 month after 1st dose; 3rd dose 6 months after 1st dose

AIDS & DEVICES

Does the applicant use any of the following:

☐ Glasses
☐ Hearing Aids
☐ Prosthetics
☐ Other: ___________________________________

ADDITIONAL INFORMATION

If there is any further information you feel should be provided as a factor that could influence the care, health, and well-being of this individual at Cornerstone Ranch, please explain:

APPLICATION SIGNATURES

I affirm that the preceding information is a complete and true statement of all the facts and circumstances relative to this participant’s application for enrollment in Cornerstone Ranch’s residential or day program.

Signature of Parent/Guardian ____ Date_____________

Signature of Applicant (if appropriate) ____ Date______________

If application was filled out by someone other than parent/guardian, please sign below:

Signature ____ Relationship _________________________ Date_____________