CORNERSTONE RANCH

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 the applicant. Incomplete applications will not be accepted.

I AM APPLYING FOR:			
☐ Residential Program ☐ Day Program			
Requested Placement Date:		Number of Days Requested:	
Days Preferred: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday			
APPLICANT INFORMATION:			
Name:			
Preferred Nickname:			
Birthdate: / /	SSN: - -	Phone:	
Current Address:			
City:	State:	Zip:	
Height:	Weight:	Gender: ☐ Male ☐ Female	Marital Status:
I give consent for Cornerstone Ranch to run a Criminal Background Check on the applicant. ☐ I understand and agree I give consent for Cornerstone Ranch to run a U.S. National Sex Offender Registry check on the applicant ☐ I understand and agree			
FAMILY INFORMATION / EMERGENCY CONTACTS:			
Mother's Name:			
Home Address:			
City:	State:	Zip:	
Preferred Email:			

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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 (Please note, the applicant's Guardianship papers must be submitted with their application):

☐ Self ☐ Mother ☐ Father ☐ Other (Please specify): _____

Who is the Med. Durable Power of Attorney for the applicant? _____

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

APPLICANT OVERVIEW

DIAGNOSIS:	
Primary Diagnosis:	Secondary Diagnosis:
Any other medical diagnosis:	

EVALUATIONS & ASSESSMENTS:

Has the applicant had any of the following? If yes, give the name of the person or agency. If assessment was completed within the last 5 years, please submit it with application.

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 concerns or needs, etc.

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

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

What techniques are usually helpful to de-escalate behaviors?

How may it effect the applicant if a peer is escalated?

Does the applicant require constant at-home supervision? ☐ Yes ☐ No

Best describe the duration for which the applicant can be left to function independently:

☐ never ☐ about 1-3 hours ☐ about 4-8 hours ☐ 12+ hours ☐ always

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?		
Tobacco	☐ Yes ☐ No	If yes to any, please explain:
Drugs	☐ Yes ☐ No	
Alcohol	☐ Yes ☐ No	
Criminal Activity	☐ Yes ☐ No	
Sexual Activity	☐ Yes ☐ No	
Abuse/Neglect	☐ Yes ☐ No	

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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? (Please note, additional documentation must be completed by potential attendant).
☐ 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

Whether routine, occasional, or unexpected assistance is needed, I give permission for Cornerstone staff to directly assist with meals, mobility, toileting, or other self-care.

☐ I understand and agree

I understand that same sex staff members would be the first to assist if available, but guarantees cannot be made due to staff scheduling and availability.

☐ I understand and agree.

Signature of Applicant, Parent, or Guardian:

ORGANIZATIONS 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	☐ Volunteering
☐ Sheltered Workshop	☐ Other: _____
☐ Group/ Family Care home	☐ Church/ Spiritual Involvement: Desires: _____

Name of Organization:	Dates Attended:	
Address:	Phone:	
Role or Involvement:		
Reason for Leaving:		
Person to contact for more information:	Phone:	E-mail:

Name of Organization:	Dates Attended:	
Address:	Phone:	
Role or Involvement:		
Reason for Leaving:		
Person to contact for more information:	Phone:	E-mail:

Name of Organization:	Dates Attended:	
Address:	Phone:	
Role or Involvement:		
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 of Applicant, Parent, or Guardian:

MEDICAL INFORMATION

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)

Medication Name:	Dosage/ Frequency:	Time of Administration:	Prescribed by:	Date Prescribed:
Medication Name:	Dosage/ Frequency:	Time of Administration:	Prescribed by:	Date Prescribed:
Medication Name:	Dosage/ Frequency:	Time of Administration:	Prescribed by:	Date Prescribed:
Medication Name:	Dosage/ Frequency:	Time of Administration:	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 be prepared to provide prescription medication in original prescription bottle.

*Please note, before medications can be administered while at the Day Program, a medication authorization form must be completed by the parent or legal guardian. If possible, a physician's order should be provided as well. All prescribed and/or over the counter medications must be provided by the applicant and stored at the Day Program in its original bottle. Expired medications will not be accepted or administered.

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, seasonal, allergies, 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 yes, one must be supplied by the applicant.

Does applicant have any dietary restrictions? ☐ Yes ☐ No

If yes, please list:

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HISTORY OF ILLNESS, HOSPITALIZATION, & SURGERY:

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

Please describe how this may impact the applicant's participation during programming:

Name & address of attending physician:

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

Please describe how this may impact the applicant's participation during programming:

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	
Vision	☐ Yes ☐ No	
Ears	☐ Yes ☐ No	
Hearing	☐ Yes ☐ No	
Scoliosis	☐ Yes ☐ No	
Chest Infections	☐ Yes ☐ No	
Chronic Cough	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	
Heart Trouble	☐ Yes ☐ No	
Kidney Disease	☐ Yes ☐ No	
Stomach Trouble	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Gastrointestinal	☐ Yes ☐ No	
Fainting Spells	☐ Yes ☐ No	

Menstrual Problems	☐ Yes ☐ No	
Muscle Problems	☐ Yes ☐ No	
Neurological Problems	☐ Yes ☐ No	
Emotional Concerns	☐ Yes ☐ No	
Psychological Concerns	☐ Yes ☐ No	
HIV	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

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

AIDS & DEVICES:

Does the applicant use any of the following?

☐ Glasses
☐ Hearing Aids
☐ Communication Device
☐ 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 the applicant 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 the applicant'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