Application for Admission

To ensure we have adequate information to evaluate your child, it is important that you try to answer all questions and complete all sections of this application. Once we receive the completed application, our admissions committee will make a decision about eligibility and schedule a preliminary evaluation to meet you and your child. Any questions about this application should be directed to Rebekah Jentes, Director of Social Work rjentes@chs-adphila.org 610-525-8800 x118

Date of Application: ______________________

Child's Name: ______________________ **Child's Date of Birth:** ______________
First, Middle, Last Month/Day/Year

Nickname/Name Preference: ______________________ **Child's SSN:** ______________

Address: ____
Street City County State Zip code

Does your child have a county supports coordinator? Yes No

If yes, what is the name of Agency and Supports Coordinator? ______________________
If no, your child needs to be registered with their County Office of Intellectual Disabilities in order to receive funding for placement at St. Edmond's Home For Children.

Parent/Legal Guardian: ______________________ **Relationship to client:** ______________

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

Best Way to Contact: Cell Phone: ______________ Home Phone: ______________

Work phone: ______________ Email Address: ______________

In Case of Emergency, if you cannot be reached, who may we contact?

1) **Name:** ______________________ **Relationship to client:** ______________

Best Way to contact: Cell phone: ______________ Home Phone: ______________

2) **Name:** ______________________ **Relationship to client:** ______________

Best way to contact: Cell Phone: ______________ Home Phone: ______________

Family Information

Father's Name: ____________ **Date of Birth:** ____________ **SSN:** ____________

Address (if different from child) ______________________________________
Street City State Zip code

Language Spoken (if other than English): ______________________________________

Mother's Name: ____________ **Date of Birth:** ____________ **SSN:** ____________

Address(if different from child) ______________________________________
Street City State Zip code

Language Spoken (if other than English): ______________________________________

Marital Status: Married Single Divorced Separated Widowed

If divorced, who has legal custody of the child?: ______________________________

Step Father/Mother Name: ______________________________

List all children in your family (include any deceased)

Name (First, Middle initial, Last)	Sex M	F	Birthdate	Address (if deceased, note cause of death)	Last Grade in School

Family Medical History

Check yes or no for each of the following medical problems/diseases for related family members. For any boxes checked "yes", note the relationship of the family member to the applicant.

Medical Problem	Yes	No	Relationship to Child	Medical Problem	Yes	No	Relationship to Child
Alcoholism/Drug abuse				Meningitis/Encephalitis			
Allergies				Pneumonia/Bronchitis			
Anemia				Rheumatic Fever			
Arthritis/Joint Problems				Sickle Cell Disease			
Asthma				Skeletal problems			
Birth Defects				GYN/Pregnancy issues			
Bladder Problems				Stroke/CVA/TIA			
Bleeding Problems				Thyroid Problems			
Blindness/Vision loss				Tuberculosis			
Cancer				Ulcers/Stomach issues			
Deafness/Hearing loss				Heart Problems/Disease			
Diabetes				Heartburn/GERD			
Digestive/GI Problems				Hepatitis A, B, or C			
Eczema/Skin Problems				Kidney Problems			
Epilepsy/Seizures				Lung Problems			
Other:				HIV			

<u>Financial Information</u>

Please enter the child's Medicaid (PA ACCESS) number: ______________________________

<u>Health Insurance</u>
Does the child have private health insurance (typically through a parent)? Yes No

Responsible Party		**Relationship to child**	**Insurance Company name**	**Insurance Company address and phone number**	
Last Name	First Name:			Street City Zip	Phone
Member ID#			Group#		

Does the child have health insurance through Health Choices (typically Keystone First or Health Partners)? Yes No

Responsible Party		**Relationship to child**	**HMO** (Keystone First or Health Partners)	**Insurance Company address and phone number**	
Last Name	First Name:			Street City Zip	Phone
Member ID#			Group#		

Does the child have separate dental insurance? Yes No

Responsible Party		**Relationship to child**	**Insurance Company name**	**Insurance Company address and phone number**	
Last Name	First Name:			Street City Zip	Phone
Member ID#			Group#		

Identify all available funding sources listed below:

Available Funding Source	Yes	No	Policy Number	Group Number of Other Number	Amount of Benefit (if SSI or trust fund)
Medicaid					
Medicaid Respite					
Medicare					
Social Security Income					
Trust Fund/Special Needs Trust					
Other:					
Other:					

Please check off and fill in the information for each non-physician therapist, healthcare/services provided who has evaluated, cared for, and/or provided services for the child.

Type of Service	Yes	No	Frequency	Length	Name of Provider (Therapist, worker)	Name of Agency	Phone number
Skilled Nursing Care							
Home Health Aide							
Physical Therapy							
Occupational Therapy							
Speech therapy							
Social worker							
Early Intervention							
Case manager							
Other:							

List ALL Physicians and Specialists who have cared for and evaluated the child. Please fill any additional specialties beyond the ones listed.

Area of Specialty or Reason for Care	Physician's Name	When (note years)	Date of Last Visit	Hospital Affiliation	Telephone Number
Primary Care					
Ophthalmology (eye care)					
Audiology (hearing)					
Dentist					
Neurology					
Gastroenterology					
Orthopedics					
Other:					
Other:					
Other:					
Other:					

Child’s Lifetime Medical History

***This information is mandatory under Pennsylvania Department of Welfare, Office of Intellectual Disabilities**

Summary of Child’s Birth History

Note: Birth records from the hospital where the child was born should be mailed to St. Edmond’s Home if applicant is accepted.

<table>
<tr><td>Child’s Date of Birth:</td><td colspan="2">Name of Hospital/Place of Birth:</td><td colspan="2">City:</td><td colspan="2">State:</td></tr>
<tr><td>Length of Labor:</td><td>Type of anesthesia (if any) used during labor & delivery:</td><td colspan="2">Type of Delivery:</td><td>Birth Weight:</td><td>Length of Pregnancy (weeks):</td><td>Apgar Scores:
1min___
3min___</td></tr>
<tr><td colspan="7">Describe mother’s health during pregnancy & identify any maternal complications or problems experienced during the pregnancy (prenatally, during labor, and/or during delivery)</td></tr>
<tr><td colspan="7">Identify any newborn problems experienced during delivery of shortly after birth:</td></tr>
</table>

PART I: Childhood Communicable Diseases

Communicable Disease	Yes	No	Date	Communicable Disease	Yes	No	Date
Measles (Rubeola)				Hepatitis B			
German Measles (Rubella)				Herpes Infection			
Whooping Cough (Pertussis)				MRSA (Methicillin Resistant Staphylococcus Aureus)			
Chicken Pox (Varicella)				CMV (Cytomegalovirus Infections)			
Mumps				Toxoplasmosis			
Polio				Other:			
Scarlet Fever				Other:			
Rheumatic Fever							

Part II: List ALL Major Illnesses, Injuries, Hospitalizations, Surgeries, Other Important Health Events Beginning at Birth up to the present date

Illness, Injury, Surgery, or Pertinent Medical Problem	Date	Treatment Provided

Part III: Immunization Record

***Please attach a copy of your child's up to date immunization record. This should include DPT or DTap, OPV or IPV, MMR (measles, mumps, rubella), Hepatitis B or Hib +Hep, and pneumococcal.**

Most recent Mantoux/PPD/TB test: Date: Result: Positive or Negative

If Positive, provide date of most recent clear chest x-ray:

Date of most recent influenza vaccine (flu shot): ____________________

Part IV: List All Medications that the Child is currently receiving

Name of Drug	Preparation or Concentration of drug (How many mg or mg are in the pill, capsule, liquid, suppository)	Dose of Drug (how much of the drug do you give? E.g. 1 tsp, 2 capsules, etc)	Frequency or times drug is given (when, how often do you give the drug?)	Reason for drug (do you know the doctor prescribed this drug- what medical problem is being treated?

Please attach additional pages if necessary.

Please list any allergies to medications or environmental conditions and the reaction

Medication or Environmental Stimulus (dust, pollen, etc)	Reaction

Part V: Assistive Technology/Equipment

Please list any devices, equipment, interventions, etc that the child currently uses at home or school to improve function, independence, inclusion, productivity, and quality of life

Mobility Aid & Adaptations	Yes	Type	Supplier (and Phone number)	When received?
Wheelchair				
Walker				
Transport chair				
Adapted stroller				
Adapted car seat				
Scooter				
Stander				
Gait trainer				
Orthotics (MAFOs, DAFOs, etc)				
Splints (hand, wrist, etc)				
Cervical/Neck/Trunk (TLSO)				
Other:				
Other:				

Medical Technological Assistive Devices	Yes	Type	Supplier (and Phone number)	When received
Mechanical Ventilation (provide settings)				
Tracheostomy				
Oxygen Supplementation		How given? How much?		
Suctioning to maintain airway		Oral/nasal/tracheal?		
Heart/Respiratory Monitor				
Feeding pump				
Ostomy Care/Special ostomy devices				
Intravenous Nutrition				
Intravenous Medication				
Dialysis				
Central lines/Catheters?				
Other:				

Assistive Listening Aids	Yes	Type	Supplier (and phone number)	When received
Hearing Aids				

Assistive Technology for Communication	Yes	Type	Supplier (and phone number)	When received

***Complete this section ONLY IF your child receives feedings by tube**

1) Does your child have a gastrostomy/G-tube or a jejunostomy/J-tube? Yes No **Which:**___________

A. What kind of g-tube/j-tube does your child have? (Note type and size)______________________________

____

B. When was the g-tube/j-tube place/inserted?___________________ What hospital?___________________
(date)

C. What was the reason for placing the g-tube/j-tube?____

D. Did your child have a Nissen Fundoplication done at the time of the tube placement? Yes No

E. Is the G-tube/J-Tube used for feedings? Yes No

F. Is the G-tube/J-tube used for medication? Yes No

G. Is the G-tube/J-tube used for hydration/fluids? Yes No

Feeding Skills Evaluation

Please list foods that your child usually eats for the following meals:

Breakfast	Lunch	Dinner	Snack

Please describe the different "food textures" your child can safely eat? (ex. Thickened liquids, pureed, regular table food, mashed, chopped, etc)____

____

List the foods your child likes "most":____

List the foods your child likes "least":____

Is your child allergic to any foods? Yes No List:_____________________________

Who usually feeds your child?______________________

Who else can feed your child?______________________

Generally, how long does it take to feed your child?_________________________________

What is the average amount of food your child usually eats at a meal?

100% 75% 50% 25% Child is very picky eater

Please describe how your child is positioned for feeding? (ex. Special seat, high chair, wheelchair, etc)

____

What utensils or tools do you use when feeding your child? (ex. bottle, cup, cup with handles, spoon, adapted spoon, sectioned dish, etc)____

Describe the specific process you use when feeding your child by mouth (include if and how much the child assists)____

____

____

Communication Inventory

Your Child's wants, needs, desires	**Describe the behaviors or signals your child uses to communicate**
Desires "attention"	
Desires an object or activity	
Indicates "hunger" or "thirst"	
Indicates "discomfort" or "pain"	
Indicates "fatigue"	
Shows happiness	
Shows sadness	
Shows anger/frustration	
Protests/refuses	

Describe any sounds that may have specific meaning:____

____

Describe any gestures that may have specific meaning:____

____

List three things that your child likes the most: 1)____________ **2)**__________ **3)**__________

List three things that your child does not like: 1)____________ **2)**__________ **3)**__________

Behaviors

Does your child have any challenging behaviors? **Yes** **No**

If Yes, please describe (include when, why, frequency, duration, etc of behaviors): ______________

____

____

What techniques are used to manage these behaviors (de-escalation methods, medications (as needed), time outs, holds, etc)____

____

*Please use this page to describe your child's usual daily routine. Include both information about a school day and a weekend day.

Morning: What time or when does your child wake up? How?

Breakfast routine:

Lunch time routine:

Afternoon Activities:

Dinner time routine:

Evening Activities:

Night time routine and sleep patterns (any needs/wants at bedtime, special sleeping arrangements, etc)

Educational Information

***Please attach a copy of the child's current IEP and/or Reevaluation Report to this application.**

Is the child currently attending school? Yes No

If yes, what is the name and address of their current school?____________________________

____

What school district is currently responsible for the child's education?____________________

If no, please explain why? ____

____

Please list any previous schools attended (include early intervention or pre-school)

Name of School	Address	Dates Attended	Briefly describe any struggles or Successes
1. ____________	____________ ____________	____________	______________________
2. ____________	____________ ____________	____________	______________________
3. ____________	____________ ____________	____________	______________________

Additional Helpful comments about your child and the care they require: ______________

____

____

____

______________________________ ____________

Signature of Person Submitting application **Date**

____

Printed name of person submitting application