7135 LOUETTA ROAD, SUITE O • SPRING, TX 77379 • (281) 257-1004

HOME PLACE OF TEXAS

A Place of Excellence for Adults with Disabilities

APPLICATION FOR ADMISSIONS

Thank you for your interest in Home Place of Texas. Please complete and return the following items:

- Application
- Medical History
- Release of Information
- Application Fee of $50.00

A thorough answer to all questions is essential. In addition to these forms, we need copies of the applicant's most recent educational, psychological, and psychiatric evaluations (if available) as well as any other information that would be helpful in determining whether Home Place can meet this individual's needs. The Admissions Committee conducts a thorough study of the information provided, determines the placement availability and suitability of each applicant, and notifies you whether or not to continue with the next step in the application process. If you have any questions, please do not hesitate to call our office.

Sincerely,

HOME PLACE OF TEXAS
Staff and Faculty

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APPLICATION FOR DAY PROGRAM ADMISSIONS

PLEASE INCLUDE A $50.00 APPLICATION FEE (NON-REFUNDABLE).
APPLICATION WILL NOT BE REVIEWED UNLESS COMPLETE.

DATE OF APPLICATION: _____

CHECK ONE:

- ☐ Day Program
- ☐ After School Program

DATE PLACEMENT DESIRED: _____

Have you had previous experience in a Day Program: ____ Yes ____ No

If Yes, when and where? _____

PERSONAL INFORMATION:

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____ CITY/STATE _____ ZIP CODE _____

CONTACT NUMBER _____ EMAIL _____ SEX _____

DATE OF BIRTH _____ PLACE OF BIRTH (CITY/STATE) _____ AGE _____

SOCIAL SECURITY NO. _____ TEXAS ID NO. _____

HCS/TxHML/CLASS PROVIDER NAME AND CONTACT INFO [*if applicable*]:

CONTACT NAME _____ CONTACT NUMBER _____

Living Arrangements: ____Independent ____ Parent/Guardian ____ Care Provider

Does Applicant have a Legal Guardian other than the Parent? ____Yes ____ No

If Yes; Please provide information below of Legal Guardian:

NAME _____ CONTACT NUMBER _____

STREET ADDRESS _____ CITY/STATE _____ ZIP CODE _____

Type of Guardianship: ____ Full ____ Property ____ Limited ____ Medical

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RESPONSIBLE PARTY:
PARENT INFORMATION

FATHER'S

NAME _____

ADDRESS _____

CITY / STATE / ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMAIL ADDRESS _____

EMPLOYER _____

MOTHER'S

NAME _____

ADDRESS _____

CITY / STATE / ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMAIL ADDRESS _____

EMPLOYER _____

CAREGIVER INFORMATION:
(IF DIFFERENT FROM ABOVE)

NAME _____

RELATIONSHIP TO APPLICANT _____

ADDRESS _____

CITY / STATE / ZIP _____

EMAIL ADDRESS _____

CONTACT NUMBER _____

BEST WAY AND TIME TO REACH YOU?

_____

EMERGENCY CONTACT INFORMATION:
(OTHER THAN PARENT/GUARDIAN)

NAME _____

RELATIONSHIP TO APPLICANT _____

ADDRESS _____

CONTACT NUMBER _____

NAME _____

RELATIONSHIP TO APPLICANT _____

ADDRESS _____

CONTACT NUMBER _____

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In the event Home Place of Texas has to close due to weather conditions or unexpected situations, every effort will be made to notify you. Please check which option you would like to be notified.

1 PERSON TO BE CONTACTED: _____

PHONE NUMBER _____

EMAIL ADDRESS _____

_____ PHONE
_____ EMAIL
_____ WEBSITE
_____ FACEBOOK

2 PERSON TO BE CONTACTED: _____

PHONE NUMBER _____

EMAIL ADDRESS _____

_____ PHONE
_____ EMAIL
_____ WEBSITE
_____ FACEBOOK

EQUIP EMPOWER ENCOURAGE

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MEDICAL INFORMATION:

A PRIMARY HEALTHCARE

APPLICANT'S PRIMARY HEALTHCARE PROVIDER/PHYSICIAN: _____

ADDRESS _____ CITY / STATE / ZIP _____

CONTACT NUMBER _____ FAX NUMBER _____

PLEASE LIST ANY OTHER SPECIALISTS WHO HAVE TREATED OR ARE TREATING THIS APPLICANT:

_____

_____

B DIAGNOSIS

PRIMARY: _____

SECONDARY: _____

TERTIARY: _____

AGE OF ONSET: _____

C MEDICATIONS

Is applicant on any regular medications? ___Yes ___ No

IF YES, PLEASE LIST BELOW:
(IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET OF PAPER.)

MEDICATION	DOSAGE/FREQUENCY	REASON	SIDE EFFECTS	NEEDS ASSISTANCE TAKING

D ALLERGIES/DIETARY RESTRICTIONS

PLEASE LIST ANY KNOWN ALLERGIES OR DIETARY RESTRICTIONS. WHAT IS (S)HE **NOT** ALLOWED TO EAT?

_____

_____

E SEIZURES

1. Does the applicant have seizures? ___ Yes ___ No
2. Frequency: ___Daily ___Weekly ___ At least once a month ___ Every Few Months
   ___ Other (please specify): _____
3. Type/Description of Seizure: _____
4. Are seizures controlled by medication? ___ Yes ___ No
5. Date of last seizure: _____

F ADDITIONAL MEDICAL

Does the applicant have any other medical problems not listed above? ___ Yes ___ No

IF YES, PLEASE LIST:

G BEHAVIORAL

Does the applicant have a history of behavioral problems? ___ Yes ___ No

IF YES, PLEASE DESCRIBE:

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BACKGROUND INFORMATION

A. SCHOOLS ATTENDED:

NAME OF SCHOOL _____ STREET ADDRESS _____ CITY / STATE / ZIP CODE _____ HIGHEST GRADE COMPLETED _____ DATES ATTENDED _____

NAME OF SCHOOL _____ STREET ADDRESS _____ CITY / STATE / ZIP CODE _____ HIGHEST GRADE COMPLETED _____ DATES ATTENDED _____

NAME OF SCHOOL _____ STREET ADDRESS _____ CITY / STATE / ZIP CODE _____ HIGHEST GRADE COMPLETED _____ DATES ATTENDED _____

B. ADULT/VOCATIONAL PROGRAM(S) ATTENDED:

NAME OF SCHOOL _____ STREET ADDRESS _____ CITY / STATE / ZIP CODE _____ DATES ATTENDED _____

NAME OF SCHOOL _____ STREET ADDRESS _____ CITY / STATE / ZIP CODE _____ DATES ATTENDED _____

NAME OF SCHOOL _____ STREET ADDRESS _____ CITY / STATE / ZIP CODE _____ DATES ATTENDED _____

C. EMPLOYMENT HISTORY:

Is the Applicant currently employed? ___ Yes ___ No

EMPLOYER NAME _____ SUPERVISOR NAME _____

STREET ADDRESS _____ CITY / STATE / ZIP _____

CONTACT NUMBER _____ FAX NUMBER _____

JOB TITLE _____

POSITION DETAILS _____

D. REFERENCES:

PLEASE PROVIDE (2) REFERENCES. (1) FROM A TEACHER AND (1) FROM A PERSONAL RELATIONSHIP

NAME _____ CONTACT NUMBER _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY / STATE / ZIP CODE _____

NAME _____ CONTACT NUMBER _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY / STATE / ZIP CODE _____

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MONDAY - FRIDAY DAILY ROUTINE

A. DESCRIBE APPLICAN'TS DAILY ROUTINE.

B. SUPPORT/ASSISTANCE. DESCRIBE SUPPORTED ACTIVITY AND THE SUPPORT USED.

C. RESTRICTIONS. DESCRIBE ANY ACTIVITIES IN WHICH THE APPLICANT IS RESTRICTED.

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APPLICANT'S ACTIVITY STATEMENTS

A. WHAT DO YOU THINK WOULD BE FUN ABOUT BEING AT HOME PLACE OF TEXAS?

B. WHAT THINGS DO YOU LIKE TO DO?

C. WHAT DO YOU WANT TO DO WITH YOUR LIFE? DO YOU WANT TO WORK? DO YOU WANT TO GO TO SCHOOL?

D. WHAT JOBS OR VOLUNTEER WORK HAVE YOU DONE?

E. DO YOU GO TO CHURCH? WHERE?

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PARENT/GUARDIAN QUESTIONNAIRE

A. DEPENDENT'S TEMPERAMENT? PASSIVE OR AGGRESSIVE? BITE, HIT SPIT, PINCH, SCRATCH, PULL HAIR, ETC?

B. WHAT FORM OF DISCIPLINE WORKS BEST WITH DEPENDENT? REDIRECTION, POSITIVE REINFORCEMENT, ETC.?

C. IS DEPENDENT TOILET TRAINED? NEED REMINDERS? REQUIRE CHANGING? HOW OFTEN?

D. WHAT IS DEPENDENT'S DEVELOPMENTAL LEVEL OF FUNCTIONING.

E. HOW DOES DEPENDENT COMMUNICATE? (I.E. NONVERBALLY, SIGN LANGUAGE, PECS, ETC.)

F. DOES DEPENDENT REQUIRE ASSISTANCE WITH EATING OR DRINKING?

G. DEPENDENTS FAVORITE ACTIVITIES ARE:

H. DEPENDENTS LEAST FAVORITE ACTIVITIES ARE:

I. PLEASE TELL US ANYTHING THAT YOU FEEL WE NEED TO KNOW TO PROVIDE THE BEST CARE FOR DEPENDENT.

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ACTIVITY INTEREST SURVEY

(P - PAST INTEREST; C - CURRENT INTEREST; N - NO INTEREST)

PLEASE CHECK THE APPROPRIATE BOX:

P	C	N	ACTIVITY
			Cards
			Games
			Arts/Crafts
			Exercise
			Sports
			Music
			Reading
			Writing
			Community Outings
			Shopping
			Walking/Wheeling Outdoors
			Watching TV
			Watching Movies
			Gardening/Plants
			Talking/Conversing
			Singing/Karaoke
			Helping Others/Volunteer Work
			Parties/Social Events
			Puzzles
			Groups/Organizations
			Bible Study
			Church
			Sewing
			Cooking/Baking
			Animals
			Computers
			Other:

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AUTHORIZATION AND RELEASE

I hereby authorize _____ (name of Applicant) to attend and participate in all of the activities of Home Place of Texas, including, but not limited to, field trips, swimming, dancing, volunteering, and exercise.

I authorize the staff and volunteers of Home Place of Texas (Staff/Volunteers) to provide transportation to and from home and field trips, swimming, dancing, volunteering, and exercise and any other activities for Applicant as required.

I represent that Applicant is capable of taking any medication he or she normally requires without supervision or oversight. I acknowledge that the Staff/Volunteers have no responsibility whatsoever to supervise or oversee the taking of any medication(s) that Applicant may require while attending and/or participating in the activities.

In case of emergency:

Contact _____at the following telephone numbers:

( ) _____-_____ or ( ) _____-_____

OR

Contact _____ at the following telephone numbers:

( ) _____-_____ or ( ) _____-_____

In case of injury, illness or other such condition, the Staff/Volunteers will attempt to make contact with the individual(s) indicated above. My signature below authorizes the Staff/Volunteers to obtain medical attention for Applicant at the nearest emergency medical facilities.

The insurance information as follows may be provided to medical provider(s) to secure payment for medical services:

INSURED _____

INSURANCE COMPANY _____

POLICY OR INSURED'S IDENTIFYIG NUMBER _____

GROUP NUMBER _____

PREAUTHORIZATION TELEPHONE NUMBER _____

MEDICAID NUMBER _____

_____ _____

Parent, Guardian, or Care Provider Date

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If the needs of the Applicant and the goals and expectations of the Responsible Person(s) appear to be a match for Home Place of Texas, such as match to be determined solely by Home Place of Texas, the Applicant and his/her Responsible Person(s) may be scheduled for an interview.

If, after the interview, the Applicant appears to continue to be a match for Home Place of Texas, such match to be determined solely by Home Place of Texas, the Responsible Person(s) may be asked to give Home Place of Texas written authorization to obtain a credit report and/or verification of employment in those cases where fees for services are required. Or, as its sole discretion, Home Place of Texas may determine such other means as it considers sufficient to secure payment for services.

Upon receipt of satisfactory credit and employment information or other arrangements to secure payment, a services agreement may be offered to the Applicant and his/her Responsible Person(s), depending upon the services to be provided.

_____ _____

Applicant Signature Date

_____ _____

Responsible Person Signature Date

_____ _____

Responsible Person Signature Date

Copy of insurance card Medicaid card Medicare card

APPLICANTS FOR SERVICES ARE NOT GUARANTEED ACCEPTANCE

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PHOTO RELEASE FORM | AUTHORIZATION AND CONSENT

Home Place of Texas often uses pictures of our clients for the purposes of promotional materials, and keeping our website up to date. Please indicate below your preference for allowing the use of these pictures for the stated purposes.

_____ I give permission for pictures of my Applicant to be used for the purposes of website/promotional material.

_____ I DO NOT give permission for pictures of my Applicant to be used for the purposes of website/promotional material.

_____
Signature

_____
Printed Name

_____
Date