



**Adjustment Training Center, Inc.**  
607 North Fourth Street • Aberdeen, SD 57401-2733  
605-229-0263 • Fax # 605-225-3455

Dear Applicant:

Attached you will find a number of forms. These forms are required to be completed in their entirety and returned to the ATC, Inc. The forms include:

1. Application - to be completed by whomever knows the individual best. This form needs to be completed in its entirety.
2. Authorization to Exchange Information – please use this form to provide the ATC, Inc with pertinent information we might need from other entities.
3. Physical examination - this form must be completed and signed by the applicant’s primary physician. The ATC will usually accept a physical examination that has been completed within one year.
4. Immunization history - this form should be completed by the applicant’s primary physician or whomever has the most complete and current records. A copy of current immunizations will work.
5. Psychological evaluation - the document should be current. This should include the diagnosis and IQ full-scale score.

The ATC, Inc., is not responsible for costs incurred in obtaining the above information. Once the above-named forms have been received by our agency, the Admissions Committee will review the information. The committee may request further information, an individual interview, or pre-placement visit. If a complete admissions packet is not completed within 6 months, the information received will be discarded. After the admissions committee makes a decision, the applicant or guardian will be notified.

Please feel free to call if we can assist you in any way.

Form #42

This agency does not discriminate because of race, color, Creed, age, sex or national origin or religion. Information Will be held in the strictest confidence. Please complete in Full, Print legibly. You may use the back of the pages Using ink if you need additional space.

DO NOT WRITE IN THIS SPACE

1. Date application sent
2. Date application rec'd
3. Date of admission

## APPLICATION FOR ADMISSION

### I. Identifying Information:

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Current Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Permanent Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Telephone Number: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Color of Hair: \_\_\_\_\_ Color of Eyes: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

Person(s) to Notify in Case of Emergency

\_\_\_\_\_  
(Name) (Relationship)

\_\_\_\_\_  
(Name) (Relationship)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Telephone: \_\_\_\_\_  
(Home) (Work)

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Citizenship Status: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Tribal Registration Number: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Services Requested: \_\_\_\_\_

Referral Source: \_\_\_\_\_  
(Name) (Agency) (Address) (Phone)

Referral Source: \_\_\_\_\_  
(Name) (Agency) (Address) (Phone)

**II. Guardianship Information:**

1. Has the applicant ever been declared incompetent by a court of law? \_\_\_ Yes \_\_\_ No

2. If yes, please complete the following:

Date of court appearance: \_\_\_\_\_

Please describe conditions of guardianship (limited, full, person, estate, etc)

Type of guardianship: \_\_\_ Full \_\_\_ Limited \_\_\_ Person \_\_\_ Estate \_\_\_ Other

Describe specifically, the terms of the guardianship established: \_\_\_\_\_

\_\_\_\_\_  
(Attach a copy of guardianship papers to the application)

3. County/Tribal Court where guardian action occurred: \_\_\_\_\_  
Individual(s) appointed as legal guardian:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Telephone Numbers: \_\_\_\_\_  
(Home) (Work)

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

**III. Financial Information**

1. Social Security \_\_\_\_\_ Yes \_\_\_ No \$ \_\_\_\_\_

2. Supplemental Security Income (SSI) \_\_\_\_\_ Yes \_\_\_ No \$ \_\_\_\_\_

3. Veterans Benefits \_\_\_\_\_ Yes \_\_\_ No \$ \_\_\_\_\_

4. Railroad Benefits \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

5. Other Benefits \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

6. If applicant does not receive any of these benefits, has he/she applied for any?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, which one(s)? \_\_\_\_\_

7. Other Income: a. Wages \$ \_\_\_\_\_

b. Interest \$ \_\_\_\_\_

stocks/bonds \$ \_\_\_\_\_

joint savings accounts \$ \_\_\_\_\_

c. Lease income \$ \_\_\_\_\_

d. Payments from U.S. government  
For land held in trust \$ \_\_\_\_\_

e. Property Owned (home, machinery, vehicles).  
\_\_\_\_\_  
\_\_\_\_\_

f. Other (specify) \_\_\_\_\_

8. Does applicant have money in a checking account? \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

\_\_\_\_\_  
Bank Name Address Account Number

Is interest added to the account balance? \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

9. Does applicant have money in a savings account? \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

\_\_\_\_\_  
Bank Name Address Account Number

Is interest paid by check? \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

10. Does applicant have Certificates of Deposit with a Bank or Savings and Loan Association?

\_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

\_\_\_\_\_  
Bank Name Address Account Number

Is interest paid by check? \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_

11. IM Account? \_\_\_\_\_ Yes \_\_\_\_\_ No \$ \_\_\_\_\_  
(Indian Land Lease)

12. Does the applicant have a Representative Payee appointed by the Social Security Administration?

\_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Name of Payee Address Phone Number

13. Life Insurance. List all policies that may make payment to beneficiary.

Name of Company	Address	Policy #	Annual Premium
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Health Insurance. List all insurance except Medicare or Medicaid which included coverage and may Make payments for physicians services, hospitalization, nursing home care or drugs, and policies that May make cash payments during any spell of illness.

Name of Company	Address	Policy #	Annual Premium
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. Prepaid Burial Arrangements. Does applicant have money in an account or on deposit?

If yes, where? \_\_\_\_\_ How Much? \_\_\_\_\_

Is interest paid applicant on this account? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Are there any specific burial instructions?

\_\_\_\_\_  
\_\_\_\_\_

#### IV. Service History

List schools, adjustments training centers, vocational rehabilitation, public and/or private hospitals, Clinic, mental health centers, and other facilities where applicant has received treatment, evaluations or training.

	<u>From</u>	<u>To</u>	<u>Place/Address</u>	<u>Reason for Leaving</u>
Current Placement:	_____	_____	_____	_____
_____	_____	_____	_____	_____
Prior Placement(s)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ICAP Service Score \_\_\_\_\_

**V. Residential Information**

Does the applicant have housing available? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, name and address: \_\_\_\_\_

If no, who will make the arrangements? \_\_\_\_\_

What types of living arrangements does applicant need? \_\_\_\_\_

\_\_\_\_\_

Does applicant require out agency's assistance? \_\_\_\_\_ Yes \_\_\_\_\_ No

What have applicant's prior living arrangements been? \_\_\_\_\_

What day-to-day responsibilities does the applicant have in present living situation (cleaning, cooking, other domestic chores, etc.)? Please describe

\_\_\_\_\_  
\_\_\_\_\_

**VI. EMPLOYMENT HISTORY**

(Please include work and volunteer experiences)

1. Has applicant been competitively employed? \_\_\_\_\_ Yes \_\_\_\_\_ No?

Employer (include address, Supervisor's name)	Dates	Type of work/duties	Reason for Leaving

2. Were any of the work experiences provided through Division of Rehabilitation Services?

\_\_\_\_\_ Yes \_\_\_\_\_ No

3. Does applicant have any work restrictions? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, be specific (Examples, lifting, standing, bending, dust, humidity, heat, noise Etc.) \_\_\_\_\_

4. Does applicant have a valid South Dakota drivers license? \_\_\_\_\_ Yes \_\_\_\_\_ NO

Drivers license # \_\_\_\_\_ Expiration date: \_\_\_\_\_

5. Has applicant been convicted of a crime? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please explain: \_\_\_\_\_

I authorize investigation of all statements contained in the application. I understand that Misrepresentations or omission of facts is cause for dismissal

The agency is a point of referral and will provide assistance into the service delivery system for eligible individuals. All approved admissions into the agency training program are considered temporary and may be times limited depending on the needs of the individual. Once admitted to the program, continuation of service will be determined by the individual's Planning team. The applicant and if appropriate his/her family are important members of this planning team.

\_\_\_\_\_  
**Signature of individual completing form**

\_\_\_\_\_  
**Date**

Address: \_\_\_\_\_

Applicant's signature or mark: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_



5. Please list siblings below:

Name	Date of Birth	Address

6. Developmental History:

At what age did applicant:

Sit up by self \_\_\_\_\_ Walk \_\_\_\_\_  
 Crawl \_\_\_\_\_ Talk \_\_\_\_\_  
 Stand by self \_\_\_\_\_ Independently toilet \_\_\_\_\_

7. All of us interact differently with different people, depending on our personalities, frequency of contact, etc. Does applicant have a close relationship to a certain family member(s)?

Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Does applicant have a difficult relationship with family member(s)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Please check the items that describe the applicant's behavior, as objectively as possible. This information is needed to plan for the person's best interests to make sure we have enough resources to help him/her.

Check all that apply

- \_\_\_\_\_ Friendly, seeks out others for social contact.
- \_\_\_\_\_ Gets along with others, but does not seek them out.
- \_\_\_\_\_ Quiet, not very active, withdrawn
- \_\_\_\_\_ Unusual or repetitive behaviors (such as rocking, finger twirling, etc.) Please describe:

What appears to "cause" this behavior? \_\_\_\_\_

How often/how long do these outbursts last? \_\_\_\_\_

\_\_\_\_\_ Intentionally hurts self. Please describe: \_\_\_\_\_

What appears to "cause" this behavior? \_\_\_\_\_

How often/how long does this happen? \_\_\_\_\_

\_\_\_\_\_ Sometimes physically aggressive toward others. Please describe: \_\_\_\_\_

What appears to "cause" this behavior? \_\_\_\_\_

How often? \_\_\_\_\_

\_\_\_\_\_ Disruptive behavior (such as frequent tantrums, screaming or other emotional outbursts).

Please describe: \_\_\_\_\_

What appears to "cause" this behavior? \_\_\_\_\_

How often/how long do these outbursts last? \_\_\_\_\_

\_\_\_\_\_ Potentially dangerous to others or self. Please describe: \_\_\_\_\_

What appears to "cause" this behavior? \_\_\_\_\_

How often/how long? \_\_\_\_\_

\_\_\_\_\_ Takes others possessions. Please describe: \_\_\_\_\_

What appears to "cause" this behavior? \_\_\_\_\_

10. Are there any behavioral changes in applicant due to recent events such as death, birth, marriage, Divorce, accident, or other trauma? Please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

11. If natural parents are divorced or separated, are there any restrictions or special feelings on home visits or relationships due to this situation? Please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

12. Please describe applicant's living arrangements for the last five years (for example: living in an institution, foster home, family, relative, independently, \_\_\_\_\_)
- \_\_\_\_\_
13. Please check applicant's most familiar environment: \_\_\_\_\_ Rural \_\_\_\_\_ Farm  
 \_\_\_\_\_ Small Town \_\_\_\_\_ City \_\_\_\_\_ Unknown
14. Please indicate the language spoken in the family home: \_\_\_\_\_
15. Does the applicant use an alternative communication system? \_\_\_\_\_
16. Please describe frequency and circumstances of applicant's contacts with the family in the past (such as letters, visits, phone calls). Can the applicant expect to receive visits from family, relatives, or friends at this agency? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
17. Should applicant make visits home? \_\_\_\_\_ Yes \_\_\_\_\_ No How often? \_\_\_\_\_
- How long should the visits be? \_\_\_\_\_
- Are any special arrangements needed? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- List relatives or friends with whom applicant can leave the agency for visits: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
18. Does applicant have a close relationship to some non-family person (for example: friend, advocate, neighbor, boyfriend/girlfriend, etc.)? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
19. Please describe frequency and circumstances of the applicant's contact with non-family persons in the past year (such as visits, letters, phone calls): \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

20. Does applicant have awareness/concerns about human sexuality? Please describe (for example: Concerns about relationships/dating, need for information/education, is sexually active, is fearful of persons of the opposite sex, etc.): \_\_\_\_\_

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21.

Please check how applicant Generally relates to:	Very Good	Good	Fair	Poor	No Contact
Teachers					
Employers					
Parents					
Siblings					
Co-workers					
Friends					
Relatives					
Persons in Authority					
Strangers					
His/Her disability					

22. What hobbies does the applicant have? Please list, including how often: \_\_\_\_\_

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23. What recreation (leisure activities) does the applicant like to do? Please describe, including how often: \_\_\_\_\_

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24. Please list any groups or organizations applicant participates in (service clubs, church groups, etc: \_\_\_\_\_

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25. Does the applicant have any food preferences? \_\_\_\_\_

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Food dislikes: \_\_\_\_\_

Are there any cultural, ethnic or religious constraints regarding food? \_\_\_\_\_

Other customs? \_\_\_\_\_

26. Does the applicant have any personal possessions or preferences of special meaning? \_\_\_\_\_

27. Does applicant use tobacco or alcohol? Please explain: \_\_\_\_\_

28. Does the applicant have any fears that the agency should be aware of (i.e., thunderstorms, the dark, etc)? \_\_\_\_\_

29. What time does the applicant generally go to bed each night? \_\_\_\_\_

What time does the applicant generally get out of bed in the morning? \_\_\_\_\_

Please check any of the following which apply to the applicant: \_\_\_\_\_ Sleep Walks;

\_\_\_\_\_ Wanders during night; \_\_\_\_\_ Has nightmares; \_\_\_\_\_ Naps during the day

Comments: \_\_\_\_\_

30. Please check the effect one or more of the following items have in helping the applicant learn:

LEARNING STYLE	MOST EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
Physical assistance/prompts			
Verbal assistance/prompts			
Demonstration			
Verbal instructions			
Written instructions			
Praise			
Constructive criticism			
Rewards			
Peer pressure			
Opinion of friends/family			

31. Please describe any special abilities or strengths the applicant has: \_\_\_\_\_  
\_\_\_\_\_

32. Please describe any unusual problems or needs the applicant has: \_\_\_\_\_  
\_\_\_\_\_

33. Please give any additional information about the applicant which you feel may help the agency's Admissions and Placement Committee to make an informed decision: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

34. Source(s) of information: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of individual completing Entry Social Assessment**

\_\_\_\_\_  
**Relationship to applicant or title:**

\_\_\_\_\_  
**Date**

## MEDICAL INFORMATION

Applicant's Name: \_\_\_\_\_  
(First) (Middle) (Last)

1. List applicant's disability(ies): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Age of onset: \_\_\_\_\_

3. Cause of disability: \_\_\_\_\_

4. Hospital Preference: \_\_\_\_\_

5. Allergies (Please describe symptoms also):

Medications(s): \_\_\_\_\_  
\_\_\_\_\_

Food: \_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

6. Does applicant have special dietary needs? \_\_\_\_ Yes \_\_\_\_ No  
(specific food consistency, adaptive equipment, positioning, etc.)

Please explain: \_\_\_\_\_

7. Does applicant have seizures? \_\_\_\_ Yes \_\_\_\_ No

Age of onset: \_\_\_\_\_ Frequency: \_\_\_\_\_

What type of seizure has been diagnosed? \_\_\_\_\_

Describe behavior prior/during/after seizure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please circle any corrective/adaptive equipment used:

Eye glasses      dentures      walker      contact lenses      orthopedic braces

Language board/book      hearing aid      cane      wheelchair      crutches      handsplints

Feeding machines      special eating utensils (list) \_\_\_\_\_

Other: \_\_\_\_\_

9. Is applicant receiving physical therapy?      \_\_\_ Yes      \_\_\_ No

Services provided: (include schedule): \_\_\_\_\_

\_\_\_\_\_

Therapist's name: \_\_\_\_\_

10. Is applicant receiving occupational therapy?      \_\_\_ Yes      \_\_\_ No

Services provided (include schedule): \_\_\_\_\_

\_\_\_\_\_

35. Please check if applicant can do the following:

A. Arm and hand use

- \_\_\_ move arms
- \_\_\_ move hands
- \_\_\_ hold objects
- \_\_\_ use both hands together
- \_\_\_ focus on people and objects
- \_\_\_ do simple 5 piece puzzle
- \_\_\_ trace simple figures

B. Feeding

- \_\_\_ swallow pureed foods
- \_\_\_ drink from cup
- \_\_\_ handle firm foods (toast)
- \_\_\_ feed self finger foods
- \_\_\_ suck from straw
- \_\_\_ use cup independently
- \_\_\_ feed self with spoon
- \_\_\_ feed self with fork
- \_\_\_ use table manners
- \_\_\_ chews using rotary motion
- \_\_\_ needs total assistance
- \_\_\_ tube feed

- C. Toileting
- toilets independently
  - indicate when wet
  - void when placed on toilet
  - stay dry all day
  - stay dry all night
  - indicate need to void
  - indicate need to have BM
  - get to bathroom independently
  - undress for toileting
  - transfer to toilet
  - flush toilet
  - rearrange clothing appropriately
  - wash hands
  - dry hands
  - change sanitary napkins (if applicable)

- | D. Dressing                         | Take off | Put On                            |
|-------------------------------------|----------|-----------------------------------|
| socks                               | _____    | _____                             |
| underwear (briefs, pants)           | _____    | _____                             |
| T-shirt                             | _____    | _____                             |
| bra (if approp)                     | _____    | _____                             |
| shoes                               | _____    | _____                             |
| shirt or blouse with buttons        | _____    | _____                             |
| pants or skirt                      | _____    | _____                             |
| jacket                              | _____    | _____                             |
| <input type="checkbox"/> button     |          | <input type="checkbox"/> unbutton |
| <input type="checkbox"/> snap       |          | <input type="checkbox"/> unsnap   |
| <input type="checkbox"/> hook & eye |          | <input type="checkbox"/> unhook   |
| <input type="checkbox"/> tie        |          | <input type="checkbox"/> untie    |
| <input type="checkbox"/> lace       |          | <input type="checkbox"/> unlace   |
| <input type="checkbox"/> zip        |          | <input type="checkbox"/> unzip    |

36. Please check if the applicant has problems with the following:  
 choking  swallowing liquids  incontinence:  bladder  bowel  both

37. Does the applicant wear diapers?  Yes  No If not, is the applicant on a toileting  
 Schedule?  Yes  No

Describe: \_\_\_\_\_

**PHYSICIANS:**

1. General Medical

Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Telephone Number: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

2. Dental

Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Telephone Number: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

3. Psychiatric

Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Telephone Number: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

4. Neurological

Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Telephone Number: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

5. Other (Dermatologist, orthopedist, ophthalmologist, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

38. Medications the applicant is currently taking:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Reason Prescribed: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

Side effects observed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have there been any changes in medications and/or dosages in the past 3 months? Why?

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39. Does applicant have any current or chronic medical problems? \_\_\_\_\_

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40. Does applicant have any current emotional problems? \_\_\_\_\_

41. Personal History

Has applicant had?

	Yes	No	Date		Yes	No	Date
Scarlet Fever	___	___	___	Recurrent Headaches	___	___	
Measles	___	___	___	Surgery (specify)	___	___	
German Measles	___	___	___	_____	___	___	
Rheumatic Fever	___	___	___	Recurrent Colds	___	___	
Mumps	___	___	___	Gallbladder Disease	___	___	
Chicken Pox	___	___	___	Bloody Stools	___	___	
Malaria	___	___	___	Recurrent Diarrhea	___	___	
Tuberculosis	___	___	___	Jaundice	___	___	
Gum/Tooth Problems	___	___	___	Stomach Problems	___	___	
Sinusitis	___	___	___	Recent Weight Gain/Loss	___	___	
Eye Trouble	___	___	___	Joint Disease	___	___	
Ear, Nose, Throat	___	___	___	Back Problems	___	___	
problems (specify)				Skin Disorders	___	___	
Head injury	___	___	___	Tumor, Cancer, Cysts	___	___	
Hay Fever/Allergies	___	___	___	Venereal Diseases	___	___	
Asthma	___	___	___	Sugar in Urine	___	___	
Shortness of Breath	___	___	___	Frequent Urination	___	___	
Chest Pain/Pressure	___	___	___	Pain on Urination	___	___	
Rapid Heartbeat or	___	___	___	Polio	___	___	
Palpitations				Hepatitis	___	___	
High Blood Pressure	___	___	___	Constipation	___	___	
Heart Murmur	___	___	___	FEMALES ONLY			
Dizziness/Fainting	___	___	___	No. of Pregnancies	___	___	
Weakness/Paralysis	___	___	___	Irregular Periods	___	___	
Insomnia	___	___	___	Severe Cramps	___	___	
Frequent Anxiety or	___	___	___	Excessive Flow	___	___	
Depression				Lack of Menses	___	___	
				PMS	___	___	

Comments: \_\_\_\_\_

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42. Family Medical History

Have any of applicant's blood relatives had any of the following? Please check appropriate Boxes and specify relationship

<u>Yes</u>	<u>No</u>		<u>Relationship</u>
___	___	Heart Attack	_____
___	___	Stroke	_____
___	___	High Blood Pressure	_____
___	___	Diabetes	_____
___	___	Asthma	_____
___	___	Hay Fever	_____
___	___	Elevated Cholesterol	_____
___	___	Congenital Heart Disease	_____
___	___	Kidney Disease	_____
___	___	Glaucoma	_____
___	___	Obesity	_____
___	___	Cancer	_____
___	___	Arthritis	_____
___	___	Epilepsy or Convulsions	_____
___	___	Hereditary Disorders or	_____
		Congenital abnormalities (specify)	
___	___	Blood Disorder	_____
___	___	Other (specify below)	_____

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## Authorization to Exchange Information

I, \_\_\_\_\_ authorize the exchange of protected and/or  
(Name of person authorizing information exchanges)

confidential information between ATC, Inc. and : \_\_\_\_\_  
(Person/organization with whom exchange authorized)

\_\_\_\_\_  
(Address of above person/organization)

**The purpose/need for such exchange is:**

- |                                |                            |
|--------------------------------|----------------------------|
| _____ Coordinate Services      | _____ Legal Purposes       |
| _____ Eligibility for Services | _____ Referral for Service |
| _____ Diagnosis & Treatment    | _____ Education Purposes   |
| _____ Other (Specify) _____    |                            |

**Specific information to be exchanged:**

- |                                |                                       |
|--------------------------------|---------------------------------------|
| _____ Immunization Records     | _____ Speech/Hearing/Language         |
| _____ Psychological Evaluation | _____ Occupational/Physical Therapy   |
| _____ Psychiatric Evaluation   | _____ Current Service Plans (ISP)     |
| _____ Counseling Reports       | _____ Independent Living Skills Evals |
| _____ Physical Examination     | _____ Vocational Evaluation Reports   |
| _____ Dental Examination       | _____ Work Experience Records         |
| _____ Social History           | _____ Current Educational Plan (IEP)  |
| _____ Neurological Reports     | _____ Legal Guardianship Document     |
| _____ Behavior Mgmt Reports    | _____ Medication History              |
| _____ Incident Reports         | _____ Behavioral History              |
| _____ ICAP                     | _____ Financial Statements            |
| _____ Personal Info sheet      | _____ Nutritional Screenings          |
| _____ Lab Tests/Results        | _____ Vision Screenings               |
| _____ Seizure reports          | _____ Other (specify)                 |

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire (insert date or event): \_\_\_\_\_. If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

\_\_\_\_\_  
(Signature Person with whom exchange authorized) \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent(s)/Legal Guardian(s) - Relationship) \_\_\_\_\_  
(Date)





