Horizons Residential Care Center
RESIDENTIAL APPLICATION
101 Horizons Lane, Rural Hall, NC 27045
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336-767-2411 ext. 2075

APPLICATION FOR ADMISSION

APPLICANT INFORMATION

Full Name: _____ Name called: _____

Date of Birth: _____ Sex: ☐Male ☐Female Race: _____

Place of Birth: City_____ State: _____ County: _____

Is applicant: ☐Natural born ☐Adopted ☐Foster Child

Is applicant: ☐Ambulatory ☐Non-ambulatory

Social Security Number:_____ Current Height: _____ Current Weight: _____

Is applicant currently living with both parents? _____ If no, with whom?

_____

Applicant's Current Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Other persons living in the home (Names & Ages):

_____

_____

Name, relationship, and telephone number of person who knows applicant best? _____

_____

DIAGNOSES

Intellectual Disability: ☐Mild ☐ Moderate ☐ Severe ☐ Profound ☐ N/A

Other Developmental Disabilities/Delays:

_____

_____

Referral Source: _____

Date of last Psychological evaluation: _____ Where? _____

Any other evaluations conducted? When? Where? _____

FAMILY INFORMATION

Mother's Name: _____

Address: _____

Phone #: _____ (home) _____ (work) _____ (cell)

Email address: _____

Occupation: _____ Employer: _____

Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

Father's Name: _____

Address: _____

Phone #: _____ (home) _____ (work) _____ (cell)

Email address: _____

Occupation: _____ Employer: _____

Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

LEGAL STATUS

Is applicant a minor (under age 18)? ☐ Yes ☐ No Custodian: _____
Is client legally competent? ☐ Yes ☐ No If no, date of adjudication: _____
Type of guardianship:

_____

Name & Relationship of guardian: _____
Address: _____ Phone #: _____

BIRTH AND DEVELOPMENTAL HISTORY

Describe mother's health during pregnancy: _____

Complications? _____

Duration of Pregnancy: Full term _____ Premature _____

Nature of Delivery: Natural _____ Breech _____ Caesarean _____ Forceps _____

Birth Weight: _____ If adopted, at what age? _____

Describe any colic or early management problems _____

Describe any feeding problems _____

Breast fed _____ Bottle fed _____ At what age weaned? _____

Age when applicant: Sat _____ Crawled _____ Walked _____

Talked _____ Was toilet trained _____ Dress self _____

Right handed or left handed? _____

When was it discovered that applicant had special needs? _____

PREVIOUS ADMISSIONS/SERVICES

1. Name of Center/Hospital/Service: _____
Address: _____
Phone # _____ Any other info _____
2. Name of Center/Hospital/Service: _____
Address: _____
Phone # _____ Any other info _____

FINANCIAL INFO

Does applicant receive: Social Security Benefits _____ If yes, amount _____

Supplemental Security Income (SSI) _____ If yes, amount _____

Medicaid _____ If yes, from what county _____

Medicaid # _____

CASE MANAGEMENT INFORMATION

Does applicant have a case manager? ☐ yes ☐ no

Name of Case Management Company: _____

Name & Telephone # of Case Manager: _____

Does applicant receive CAP/MR-DD funding? ☐ yes ☐ no If yes, from which county? _____

MEDICAL INFORMATION

Primary Care Physician: _____
Address: _____
Office phone: _____

Dentist: _____ Phone #: _____
Address: _____
Insurance Company: _____
Group name: _____
Group number or Medicaid Number: _____
Policy Number: _____
Name of person on insurance card: _____

Other Physicians or Medical Centers used:

_____
_____

Past Surgeries or Procedures? When? Where? Any surgeries planned for the future?

Past accidents and injuries that required medical treatment? Type? Hospitalized where?

What diseases or disorders tend to occur in members of the applicant's family (blood relatives)?

Have all immunizations been completed? _____ Screened or vaccinated for Hepatitis B? _____
(Complete immunization record to be submitted prior to actual admission)
List any special medical procedures used such as suctioning, nasal gastric tube feedings, gastrostomy feedings, special skin care, postural drainage, diet, braces, etc.: _____

Does applicant have any of the following:

* known allergies? _____ If yes, please describe, including reactions: _____

* history of seizures? _____ If yes, please describe the type, frequency, and duration: _____

* visual impairment? _____ If yes, please describe: _____

* hearing impairment? _____ If yes, please describe: _____

*history of ear infections? _____ If yes, how often and please describe: _____

_____

_____

* speech impairment? _____ If yes, please describe: _____

_____

_____

* mobility impairment? _____ If yes, please describe: _____

_____

_____

* behavioral issues? _____ If yes, please describe: _____

_____

_____

If applicant is female, what age did menstruation begin and describe how applicant handles menstrual cycle:

_____

Does applicant have any other frequent illnesses or problems such as colds, earaches, skin problems, high fevers, diarrhea, etc. _____ If yes, please describe: _____

_____

_____

Does applicant receive medical attention more than quarterly from a doctor or nurse? ☐ Yes ☐ No

Does applicant receive services from any of the following? How often?

SERVICE	FREQUENCY
Nurse	
Occupational Therapist	
Physical Therapist	
Speech Therapist	
Psychologist	
Psychiatrist	
Other (specify)	
Other (specify)	

MEDICATIONS

Is applicant currently on any prescription or over the counter medications? ☐ Yes ☐ No

If yes, please list the name of each medication, how much medication is given each time, when each medication is given, and what is the purpose of each medication:

Name of Medication	Dosage of Medication	Times of Medication	Purpose of Medication

____			

Describe any special procedures for giving medications:

_____

_____

How does applicant respond to taking medications:

_____

_____

EATING

Does applicant eat by mouth? _____ By gastrostomy tube? _____ Other? _____
What times does applicant eat each day? _____
Is applicant on any special diet or have special diet needs? _____ If yes, describe fully: _____
_____
What type of food does applicant eat: Solid? _____ Mashed? _____ Chopped? _____ Pureed? _____
Applicant's most liked foods: _____
_____
Applicant's most disliked foods:
_____
_____
Does applicant self feed? _____ Does applicant use: Knife? _____ Fork? _____ Spoon?_____
What type of knife/fork/spoon is used?
_____
Does applicant finger feed? _____ Any problems with chewing, swallowing, sucking, choking, or eating inedibles? _____ If so, describe: _____
_____
Desribe applicant's appetite:_____
_____
_____
Does applicant drink from a cup? _____ If yes, what type of cup?
_____
What level of assistance is needed for applicant to complete a meal or snack: Does independently ?
_____
Needs some assistance (describe)
_____ Needs a lot of assistance (describe) _____

Describe anything that you feel we would need to know about the applicant regarding eating habits, mealtime behaviors, equipment, level of assistance, etc.: _____
_____
_____

AMBULATION

Does applicant walk? _____ If yes, does applicant walk: Independently? _____
With some assistance? _____ With a lot of assistance? _____ With a walker? _____
If applicant does not walk, can applicant do any of the following: Roll _____ Crawl _____
Pull to stand _____ Use scoot board _____ Move self from place to place _____
Is applicant prone to falls? _____ If yes, how often does applicant fall? _____
Describe any problems or concerns with ambulation?
_____
_____

CORRECTIVE DEVICES

Does applicant have any corrective devices such as eyeglasses, AFOs (ankle-foot orthosis), hand splints, knee immobilizers, knee braces, short leg braces, abduction wedges, head support collars, scoliosis jacket, wrist supports, or any other device? _____
If yes, list devices and when they are supposed to be worn?
_____
_____
_____

TOILETING

Is applicant toilet trained? _____ If yes, does applicant go to the bathroom alone? _____
Does applicant use toilet paper? _____ Does applicant indicate a need to use the bathroom? _____
If toilet trained, how often does applicant go to the bathroom? _____
Frequently constipated? _____ Frequently impacted? _____ Treatment used? _____
How often does applicant have a bowel movement? _____
Describe any special problems or concerns with toileting? _____
_____
_____

SLEEPING

Approximate time applicant goes to bed_____ Time applicant wakes up _____
Any resistance to going to bed? _____ If yes, describe: _____
Does applicant: Sleep soundly? _____ Wake up during the night? _____ Get out of the bed? _____ Become restless during the night _____ Sleep alone in the bed? _____ Use bedrails? _____
What type of bed does applicant sleep in? _____
Gets a nap during the day? _____ What time of day and for how long? _____

Describe any special bedtime routines and any problems or concerns regarding sleeping:

_____

_____

BATHING

Does applicant enjoy bath time? _____ If no, describe behaviors:_____

_____

What is applicant bathed in? _____

Does applicant wash self: Independently _____ With some assistance (describe)

_____ With a lot of assistance (describe) _____

Describe any bath time routines and any problems or concerns regarding bathing: _____

_____

_____

COMMUNICATION

How does the applicant communicate best?

Does the applicant use assistive communication devices?

Does the applicant rely on prompting to assist with communication?

EDUCATION / DAY PROGRAMMING

Does applicant presently attend any program(s) or school(s) in your community?
Example: public schools, workshop, day program, etc.

Name of school/program: _____

Address: _____

Contact Person (teacher/job coach):_____ Phone:_____

Days per week:_____ Hours per week:_____ Date enrolled:_____

Please attach the most recent IEP if in school services

ADDITIONAL INFORMATION

List any equipment that would accompany your family member:

_____

_____

Please give any other information you think will be helpful for us to know about your family member:

_____

Describe any goals you would like to see applicant work on:

Signature of person completing application _____
(type if submitting digitally)

Date: _____

SUBMIT