EXCEPTIONAL OPPORTUNITIES, INC.
Application for Services
Exceptional Employment / Day Habilitation

Legal Name:_____
(first) (middle) (last)

Address:_____

_____ Telephone:_____

Applicants Social Security Number:_____

County of Residence:_____ Registered Voter: yes no

Birthdate:_____ Birthplace:_____
(hospital) (town)

Marital Status:_____ Sex:_____

Church Preference:_____

Fathers Full Name:_____

Fathers Address:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Mothers Full Name:_____

Mothers Address:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Legal Guardian:_____ Telephone:_____

Address:_____

Please attach a copy of the following paperwork:

1. Guardianship papers
2. Managed Care Organization assignment and copy of card
3. Completed Interest Checklist for Day Habilitation
4. Proof of Waiver eligibility

SIBLINGS IN FAMILY:

Name:_____ Birthdate:_____

Address:_____

Name:_____ Birthdate:_____

Address:_____

Name:_____ Birthdate:_____

Address:_____

Name:_____ Birthdate:_____

Address:_____

Name:_____ Birthdate:_____

Address:_____

Name:_____ Birthdate:_____

Address:_____

Others in household:_____

_____

Language Spoken / Understood:_____

Person To Contact in Case of an Emergency:_____

Address:_____ Phone:_____

Relationship to Applicant:_____

Source of Referral:_____

Additional Comments:_____

_____

_____

MEDICAL INFORMATION

DISABILITY INFORMATION:

Primary Disability:_____

Source of Diagnosis:_____

Other Diagnosis':_____

Medical Insurance Coverage:

Type_____ Number:_____

Type_____ Number:_____

Medical Clinic Preferred:_____

Medical Physician Preferred:_____

Eye Doctor Preferred:_____

Does the applicant wear glasses? yes no Hearing Aids? Yes no

Dentist Preferred:_____

MEDICATIONS

Name:_____Dose:_____ Frequency:_____

Pharmacy:_____ Prescribing Physician:_____

Reason for Medication:_____

Name:_____Dose:_____ Frequency:_____

Pharmacy:_____ Prescribing Physician:_____

Reason for Medication:_____

Name:_____Dose:_____ Frequency:_____

Pharmacy:_____ Prescribing Physician:_____

Reason for Medication:_____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

Name:______________________Dose:_______________ Frequency:__________

Pharmacy:_______________________ Prescribing Physician:_______________

Reason for Medication:____

(Attach a list of medications, dosage, and when taken if more space is needed)

History of Substance Abuse? Yes No

History of Mental Illness? Yes No

Any criminal history? Yes No

History of Sexual Abuse or has been a Perpetrator? Yes No

ALLERGIES:

Medication Allergies and Type of Reaction?_____

_____

Food Allergies and Type of Reaction?_____

_____

Other Allergies and Type of Reaction?_____

_____

DIET – Is applicant on a special diet as ordered by a medical doctor? Yes No

If yes, type of diet and reason for the diet?_____

_____

ACTIVITY

1) List all of the activities or limitations that the applicant is restricted from as ordered by a medical professional.

_____

_____

_____

2) Does the applicant have any physical disabilities that require the use of special devices? (wheelchair, braces, walker, orthopedic shoes, splints, canes, etc.)

Please explain:_____

_____

_____

_____

MEDICAL HISTORY

1) List all operations/injuries/illnesses applicant suffered which required hospitalization:

Date	Nature of Hospitalization	Outcome

2) Illnesses (List Year)

Chicken Pox_____ German Measles_____ Pneumonia_____ Hepatitis A_____

Measles_____ Polio_____ Hepatitis B_____ Mumps_____ Whooping Cough_____

Tuberculosis_____ Scarlet Fever_____ Rheumatic Fever_____

Is applicant prone to any of the following? (please check if yes)

Asthma	_____	Strep Throat	_____
Colds	_____	Urinary Tract Infections	_____
Constipation	_____	Vaginal Infections	_____
Diarrhea	_____	Nose Bleeds	_____

Does the applicant have seizures? YES NO

Age of Seizure onset:_____ Type of Seizure:_____

Date of last seizure:_____ Frequency?_____

IMMUNIZATIONS: (list dates)
DPT/TD Series_____
Polio Series_____
Measles (Rubeola)_____
German Measles (Rubella)_____
Mumps_____
Date of Last Mantoux_____ Result:_____
Has applicant ever had a positive Mantoux? YES NO
Date of last chest X-ray_____
Date of last Tetanus Shot_____

Hospital Preferred:_____

Pharmacy Preferred:_____

Does Applicant have a Burial Fund? Yes No

EDUCATIONAL HISTORY

Name/Address of Schools Attended Grade/Level Dates Attended

_____

_____

Other Educational Programs Attended:_____

_____

VOCATIONAL HISTORY

Have you ever been employed in a Sheltered Workshop? YES NO

If Yes, Name of Sheltered Workshop:_____

Have you ever worked at a job in the community? Yes No

If Yes, please list past employers and approximate dates of employment:

Employer:_____ Date:_____ Rate of Pay:_____

Employer:_____ Date:_____ Rate of Pay:_____

Employer:_____ Date:_____ Rate of Pay:_____

Employer:_____ Date:_____ Rate of Pay:_____

List some of your previous job responsibilities and work experiences. What tasks did you perform?

_____

_____

_____

Signature of person completing this application:_____

Relationship to the applicant:_____

Date this application was completed:_____

(Fill out by Exceptional Opportunities Personnel)
Date Application Received:_____
Staff Member Receiving Application:_____