Exceptional Opportunities, Inc.
Supported Community Living Admission Application

Legal Name_____
(first) (middle) (last)
Address_____
Telephone_____
Applicant's Social Security Number_____
Date of Birth_____ Birthplace_____
(hospital) (town)

Marital Status S M D W Sex M F Height_____ Weight_____
Hair Color_____ Eye Color_____
Other Identifying Marks_____
Religious Preference_____
Please indicate whether it is ok to attend another church Y N
Comments_____
County of Residence_____ Registered Voter Y N

Name of Case Manager_____
Address_____
Phone Number_____E-mail_____

Father's Full Name_____
(first) (middle) (last)
Address_____
E-mail_____Telephone_____
Birthplace_____
Occupation_____Education_____
Military Service_____Workplace_____
Work Telephone_____

Mother's Full Name_____
(first) (middle) (maiden) (last)
Address_____
E-mail_____Telephone_____
Birthplace_____
Occupation_____Education_____
Military Service_____Workplace_____
Work Telephone_____
Parents Marital Status_____ Religion_____
Date of Marriage_____Place_____

Legal Status of Applicant_____
Legal Guardian_____ Telephone_____
Address_____
Guardianship number_____ Court_____ Date_____
Representative Payee for Finances_____
Address_____
E-mail_____ Telephone_____
Other_____

Other Children in Family (if they have a disability, please circle the name)
1) Name_____Birthdate_____
Address_____
2) Name_____Birthdate_____
Address_____
3) Name_____Birhtdate_____
Address_____
Others in household _____
_____

Language Spoken/Understood_____

Emergency Contact Person (other than parent/guardian)_____
Address_____
Telephone_____ Relationship_____
E-mail_____
Source of Referral_____
_____

Are you currently:	Occupying substandard housing	Y	N
	Involuntarily displaced	Y	N
	Paying more than 50% of income for rent	Y	N

Additional Comments_____
_____
_____

Does applicant have history of substance abuse? Y N
Does applicant have history of mental illness? Y N
Comments_____
_____

Does applicant have any allergies to food, medication, other? Y N (please list)
_____Type of reaction_____
_____Type of reaction_____
_____Type of reaction_____
_____Type of reaction_____
_____Type of reaction_____

Is the applicant on a special diet ordered by the physician? Y N
Type of Diet_____ Date started_____
Reason for diet_____
*(must have written statement from physician if special diet is needed)

List all activities or limitations the applicant is restricted from as ordered by physician.

_____

_____

*(must have written statement from physician if any limitations)

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

_____

List Preference of Provider:

Physician_____ Date Last Exam_____

Address/Phone_____

Hospital_____

Address/Phone_____

Dentist_____ Date Last Exam_____

Address/Phone_____

Does applicant have dentures? Y N

Optometrist_____ Date Last Exam_____

Address/Phone_____

Does applicant wear glasses? Y N

Pharmacy_____

Address/Phone_____

Mortician_____

Address/Phone_____

Does applicant have a burial fund? Y N

Current Medications (prescribed & over-the-counter)

Name	Dose	Frequency	Reason for Medication

Past Medications

_____

_____

_____

_____

Medical History
List all operations, injuries, illnesses which required hospitalization.
Date Reason Name/Address Hospital
_____
_____
_____
_____

Illnesses (list year)
_____Chicken Pox _____German Measles _____Pneumonia
_____Measles _____Polio _____Croup
_____Mumps _____Whooping Cough _____Tuberculosis
_____Scarlet Fever _____Rheumatic Fever _____Hepatitis A or B
Other_____
_____
_____

Is applicant prone to any of the following? (please check all that apply)
_____Asthma _____Strep Throat _____Colds
_____Constipation _____Diarrhea _____Weight Gain
_____Nose Bleeds _____Vaginal Infections _____Urinary Tract Infect.

Does applicant have seizures? Y N
Age of onset_____ Type of Seizure_____
Date of Last Seizure_____ Frequency_____

Immunizations (list date)
DPT/TD Series_____
Polio Series_____
Measles (Rubeola)_____
German Measles (Rubella)_____
Mumps_____
Date of Last Mantoux_____ Results_____
Has applicant ever had a positive Mantoux? Y N
Date of Last Chest X-ray_____
Date of last Tetanus shot_____
Flu shot_____ Pnuemovax_____

Other
Age menstruation began_____ Date of last period_____
Does applicant have regular menstrual cycles? Y N
If no, please comment_____
Has applicant ever used birth control? Y N
Method_____
Date started_____ Date if Discontinued_____

Educational History

Name/Address of Schools Attended Grade Level Dates Attended Year Graduated

_____
_____
_____

Name/Address of Programs Attended Dates Attended Comments

_____
_____

Vocational History

Has the applicant ever been employed? _____Sheltered _____Competitive

Current Employer or Day Program_____

Address/Phone_____

_____

Dates Attended_____

Job Responsibilities_____

_____

Past Employers or Day Programs_____

Address/Phone_____

_____

Dates Attended_____

Job Responsibilities_____

_____

Reason for Leaving_____

Describe Previous Living Arrangements_____

_____

_____

Describe Previous/Current Services Received_____

_____

_____

_____

Please include any other pertinent information that might allow the applicant to be better served_____

_____

_____

_____

Signature of Person Completing Application

Relation to Applicant

Date Completed