APPLICATION FOR ADMISSION

Scott Key Center, Inc.
1050 Rocky Springs Road
Frederick, Maryland 21701
Office (301) 694-1600 FAX (240) 629-6016

I. Applicant/Family/Contact Information

Name of Applicant:_____ Date of Birth:_____
First Middle Last

Home Address:_____ Home Phone:_____

_____

County of Residence:_____ Length of County Residency:_____

Social Security Number:_____ Medical Assistance Number:_____

Medicare No.:_____ Other Ins. No.:_____ Company:_____

Receive S.S.I. Benefits? Yes/No (circle one) If not, any other income (death benefit, Social Security, Pension etc.)? _____

Client's Monthly Income?_____

Father's Name:_____ D.O.B._____ Mother's Name:_____

Place of Occupation:_____ Education:_____

Place of Business:_____ Business Phone:_____

Mother's Occupation:_____ Education:_____

Place of Business:_____ Business Phone:_____

If applicant does not live with parent(s), who is the person responsible?_____

Brothers/Sisters (check before name if living at home):

Name(s):	D.O.B.	Occupation:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Others Living In Home:

Name(s):		Relationship to Applicant:
_____	_____	_____
_____	_____	_____
_____	_____	_____

II. Applicant's Background Medical Information

Mental/Physical handicaps (please provide medical diagnosis, if known):

Primary:_____

Secondary:_____

(please continue on to page 2.)

Date of Applicant's last physical evaluation:_____ Physician _____

Address:_____ Office Phone:_____

_____

Date of last Psychological evaluation: _____ Psychologist:_____

Family Physician or Clinic:_____

Address:_____ Office Phone:_____

_____

Other Specialists or Special Clinics: Yes /No (circle one) If yes, who and where:_____

_____ Purpose:_____

Results/Recommendations:_____

_____

Hospitalized:_____ Name of Hospital:_____

Address:_____

Other Hospital:_____

Address:_____

Results/Recommendations:_____

_____

Does Applicant currently experience or is applicant candidate for seizures?:_____ Type:?_____

Age at onset:_____ When/where last?:_____ Frequency:_____

Medications/dosage(s) used:?_____

III. Applicant's Emergency Contact Information

Who should be contacted in case of an emergency other than responsible person listed on page 1? (friend, neighbor, other relative, etc.)

1. Name:_____ Relationship:_____

   Address:_____ Phone:_____

2. Name:_____ Relationship:_____

   Address:_____ Phone:_____

IV. Applicant's General Assistance Needs

Is applicant "ambulatory"? Yes/No (circle one) If not, how much assistance is needed? Uses cane?: Yes/No (circle one)

Has braces? Yes/No (circle one) Needs leading?: Yes/No (circle one) Requires help of another person?: Yes/No (circle one)

(please continue on to page 3.)

IV. Applicant's General Assistance Needs (continued from page 2.)

If so, in what manner? _____ Needs help only to raise of sit?: Yes/No (circle one)

Is applicant partially confined to a wheelchair?: Yes/No (circle one) Is applicant totally confined to a wheelchair?: Yes/No (circle one)

Is applicant totally dependent? Yes/No (circle one) Is applicant toilet-trained for urinating?: Yes/No (circle one) For bowels?: Yes/No (circle one)

Makes needs known?: Yes/No (circle one) Verbally?: Yes/No (circle one) What word(s)?: _____

Does applicant "gesture"?: Yes/No (circle one) If yes, what gesture(s):?_____

Does applicant dress self?: Yes/No (circle one) Undress self?: Yes/No (circle one) What help is needed?:_____

Does applicant feed self?: Yes/No (circle one) Use spoon?: Yes/No (circle one) Use fork?: Yes/No (circle one) Use knife?: Yes/No (circle one)

Drink from a glass? Yes/No (circle one) Cup?: Yes/No (circle one) Allergies (food, drug, pollen, etc.)? _____

Restrictions (physical, recreational, work)?_____

Speech: No speech:_____ Single words:_____ Sentences:_____

Understanding:_____

Does applicant use words or expressions (such as "pee" for urine) that may not be understood?: _____

If yes, please describe:_____

Hearing: Normal?: _____ Impaired? _____ Hearing aide used? _____

Vision: Normal?: _____ Impaired?: _____ Glasses worn:? Yes/No (circle one)

V. Applicant's General Personality/Character Traits

Particular mannerisms or habits to be noted: _____

_____

Is applicant shy?: Yes/No (circle one) Openly friendly?: Yes/No (circle one) Any behavior problems?: _____

If yes, please describe: _____

Does applicant have any particular fears of animals, height, elevators, escalators, sirens, vehicles, people, etc.?:

If yes, please describe to what? _____

Describe applicant's reaction(s): _____

In general, how does applicant react to anxiety or a stressful situation? Does he/she cry, withdraw, throw tantrums, etc?:

Please describe:_____

Does applicant relate well to others?: Yes/No (circle one) Does he/she seek friendships or is he/she a loner?:_____

Describe any alliances or frictions in family or residence to be noted by SKC:_____

_____

Is applicant abusive to others?; Yes/No (circle one) To self?: Yes/No (circle one)

(please continue on to page 4.)

V. Applicant's General Personality/Character Traits (continued from page 3.)

How does applicant relate to adults in authority? _____

_____

Has applicant had experience of being cared for by adults other than family members? Yes/No (circle one) If yes, please describe:

_____

Accustomed mode/method of reassusrance/ reward for doing a good job? (high five, "good job", etc.):

_____

VI. Applicant's Medicinal Needs

Is applicant on any medication(s)?: Yes/No (circle one)

Prescribed medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____

VII. Applicant's General Activities/Interests/Community Involvement

Schools/Programs/Work, etc.

Name:	Type	Dates	Reason for leaving
_____			
_____			
_____			
_____			

Was applicant's attendance regular and punctual?: Yes/No (circle one) Comments: _____

Institutional/Residential Admissions:

Name and Address:	Type	Date entered	Date Left
_____			
_____			
_____			
_____			

(please continue on to page 5.)

VIII. Applicant's General Physical Information

HEIGHT: _____ WEIGHT:_____ MARITAL STATUS:_____

COLOR OF EYES:_____ COLOR OF HAIR:_____ LANGUAGE:_____

IDENTIFICATION MARKS:_____

Signature:_____ Date:_____

Witness:_____

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FOR OFFICE USE ONLY

Date of Admission:_____ Program:_____

Reason for Non-Admission:_____

Date of Withdrawal/Transfer:_____ Reason:_____

COMMENT(S):_____

_____

_____

_____

Signature:_____

Position:_____