Blue Ridge Area Foundation
Application / Screening Form

Date of Application:_____
Person Completing Form:_____
Relationship to Client:_____

Services Requested:
_____Vocational/Day _____Residential

Referral Information:

Referral Source:_____
Reason for Referral:_____
_____
_____
_____

Client Data:

Client Name:_____
Address:_____
Phone #:_____
Date of Birth:_____
Medicaid ID#:_____
Medicaid County of Origin:_____
Social Security #:_____
Unique Client ID # (If applicable):_____
Sex:_____ Race:_____

Data of Responsible Person:

MCO:_____
Care Coordinator Name/Phone #:_____

Guardian:_____
Guardian Phone #:_____
Guardian Address:_____
Date of Adjudication:_____
County of Adjudication:_____

Diagnosis:

AXIS I:_____
AXIS II:_____
AXIS III:_____

Date of Last Psychological Evaluation:_____
Measured IQ:_____
Cause of Disability, if known:_____
_____

Previous Placement Information:

Current Residential Arrangement: _____DDA Group Home _____Rest Home
_____Private Home _____ICF/MR
_____Family Care Home _____Institution
_____Other (Specify)_____

Former Residential Services:	From:	TO:	Reason for Termination

Current Day Placement: _____School _____Comp Ed
_____Other (Specify)_____

Former Day Services:	From:	TO:	Reason for Termination

Assessment Information

1. Ambulation

_____Ambulatory (If checked, go to #2)
_____Partially Ambulatory
_____Non-Ambulatory – Mobile
_____Non-Ambulatory – Non-Mobile

Ambulation Aids Needed: _____Wheelchair _____Cane _____Braces
_____Handrails _____Personal Assistance
_____Walker _____Gait Belt
_____Other_____

2. Independent Living

Eating Skills

____Uses Utensils Correctly
____Feeds Self w/out Spilling
____Feeds Self With Fingers
____Feeds Self With Adaptive Equipment
____Must be Fed

Toileting Skills

_____Never Has Accidents
_____Nighttime Accidents Only
_____Occasional Accidents
_____Frequent Accidents
_____Wears Attends

Leisure Skills

____Entertains Self
____Needs Direction From Others
List Interests_____
_____

Level of Supervision

_____Outdoors Unsupervised
_____Indoors Unsupervised
_____Continuous Supervision

Grooming Skills

Bathing - Level of Assistance Needed:_____

_____

Dressing - Level of Assistance Needed:_____

_____

Brushing Teeth – Level of Assistance Needed:_____

_____

3. Vision

_____Normal Vision
_____Wears Corrective Lenses
_____Legally Blind
_____Unable to Determine

4. Hearing

_____Normal Hearing
_____Hearing Aid
_____Some Hearing Loss
_____Deaf
_____Unable to Determine

5. Allergies _____

_____

_____

_____

6. Height_____

Weight_____

7. Date of last Physical Examination_____

Physician Name, Phone Number_____

Date of last Dental Examination_____

Dentist Name, Phone Number_____

8. Special Medical Concerns_____

_____

_____

_____

9. Seizures _____Yes _____No

If yes, please provide a description of a typical seizure:_____

_____

_____

_____

_____

10. Socialization Skills

_____Initiates Interactions With Familiar People
_____Initiates Interactions With all People
_____Never or Rarely Interacts with Others

11. Communication

Expressive

_____Uses Expressive Language Clearly
_____Uses Expressive Language With Difficulty
_____Uses Gestures to Express Desires
_____Uses Sign Language to Express Desires
_____Uses Some Vocalizations
_____Uses Assistive Communication Device/ System
_____Unable to Communicate Wants and Needs

Receptive

_____Comprehends Most Spoken Language
_____Comprehends Limited Spoken Language
_____Responds to Gestures/ Auditory Cues
_____Responds to Sign Language
_____Does not Respond to Communicative Stimuli

12. Medication

Medication	Dosage/Frequency	Route	Special Instructions/ Compliance Problems	Purpose of Medication

Self Administration

_____Able to Take Medication in Right Doses at Right Time
_____Can Prepare and Take Medication With Reminders
_____Can Take Medications Once Prepared
_____Unable to Take Medication Without Assistance

13. Behavior Concerns

Does the applicant display any of the behavior concerns listed below? If so, please Rate according to severity: **1 – Severe 2 – Moderate 3 – Mild**

_____NONE
_____Assaultive
_____Exhibits Self-Stimulation
_____Verbal Threats
_____Runs Away Purposefully
_____Damages Property
_____Lies
_____Inappropriate Sexual Behavior
_____Other_____

_____Steals
_____Low Tolerance for Being Touched
_____Frequently Non-Compliant
_____Loses Temper Easily
_____Wanders Away Aimlessly
_____Cries/Screams Excessively
_____Self Injurious

14. Academic Abilities

_____Reads (Specify Level:_____)
_____Writes
_____Basic Math Skills
_____Ability to Prepare/ Follow a Budget

15. Sleep Patterns

Please describe the applicants sleep patterns:_____
_____

Preferences

List any preferences the individual has that would make transition into placement easier (Objects, interaction styles, foods, etc)_____
_____
_____
_____
_____
_____
_____

Desired Outcomes of Placement

What led you to seek placement at this time?_____
_____
_____
_____
_____

What needs of the applicant do you hope to have met through placement?_____
_____
_____
_____
_____

What future goals does the applicant have?_____
_____
_____
_____
_____

_____ _____
Applicant or Guardian Date

_____ _____
Case Manager or Referring Agency Date

To be completed by BRAF Representative

_____Declined

Date applicant notified of declination:_____
Reason for declination:_____
_____
_____
_____
Referrals Made:_____
_____
_____
_____

_____Wait List

Date applicant notified of Wait List Status:_____
Referrals Made:_____
_____
_____
_____

_____Accepted

Date applicant to begin service:_____
Attach any additional Admission Information, if needed.