

MARTHA LLOYD COMMUNITY SERVICES

190 West Main Street
Troy, PA 16947-1199
Telephone (570) 297-2185
Fax (570) 297-1019
Email information@marthalloyd.org

APPLICATION COVER PAGE

Please complete all parts of the enclosed application. To ensure prompt attention to the application, complete the application checklist, sign, and return with the application.

APPLICATION CHECKLIST

- Recent Photo Included With the Application.
- Personal Data Application Form Completed and Signed
- Medical History Completed
- Assessment of Skills/Abilities/Individual Characteristics Completed
- Financial Data Completed and Signed
- HIPAA Consent To Use and Disclose Health Information Signed
- Authorization Forms Sent to Appropriate Agencies
- Most Recent Psychological or Psychiatric Evaluation
- Other Educational or Program Information

Signature _____ Date: _____

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PERSONAL DATA APPLICATION FORM

Please include a recent photograph

Name of Applicant: _____
(last) (first) (middle)

By what name does the applicant like to be called? _____

Birth Date: _____ Age: _____ Birthplace: _____ Sex: _____

Social Security No: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

FATHER'S INFORMATION

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

Address: _____
(street) (apt. no.)

_____ (city) (state) (zip)

Phone: _____

Email Address: _____ Fax: _____

Employer: _____

Employer's Address: _____
(street) (apt. no.)

_____ (city) (state) (zip)

Phone: _____

MOTHER'S INFORMATION

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

Address: _____
(street) (apt. no.)

_____ (city) (state) (zip)

Phone: _____

Email Address: _____ Fax: _____

Employer: _____

Employer's Address: _____
(street) (apt. no.)

_____ (city) (state) (zip)

Phone: _____

GUARDIAN INFORMATION (If Parents are deceased)

Name of Guardian _____
(last) (first) (middle)

Address: _____ Phone: _____

Business Address _____ Phone: _____

Emergency Contact (if parent/guardian unavailable): _____ Phone: _____

Referred by: _____ Phone: _____

Exact Diagnosis: _____

By Whom/Specialty: _____ When? _____

Address/Phone: _____

In what group homes has the applicant participated? (Schools, residential programs, vocational programs etc...)
List names and dates of attendance

How does he/she choose to spend leisure time?

Where does he/she enjoy going? (Stores, movies, church, etc...)

Alone? _____ If no, accompanied by whom? _____

FAMILY STRUCTURE AND INFORMATION

How many live in the home? _____

Please list (include relationship and age): _____

Please list brothers and sisters. If married, include name of spouse:

Name: _____ Birth Date: _____
(last) (first)

Address: _____ Phone: _____

Name: _____ Birth Date: _____
(last) (first)

Address: _____ Phone: _____

Name: _____ Birth Date: _____
(last) (first)

Address: _____ Phone: _____

No person shall on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination during application or while attending Martha Lloyd Community Services.

Signature: _____ Date: _____
(parent or guardian)

Martha Lloyd Community Services
Troy, Pennsylvania 16947

MEDICAL HISTORY

Name: _____ Date of Application: ____/____/____

Religion: _____ Birthplace: _____

Exact Diagnosis: _____

Name & Address of Insurance Co.: _____

Policy No.: _____ Group No.: _____ Subscriber: _____

Medicare No.: _____ Medical Assistance No.: _____

Please indicate below any physicians or professional people who provide treatment to the individual (ie. family physician, dentist, psychiatrist, neurologist, etc.)

Name	Profession	Phone
1. _____	_____	_____

Address: _____

2. _____

Address: _____

3. _____

Address: _____

4. _____

Address: _____

Please note with an asterisk (*) any of the above who will continue to provide care if the individual is admitted to MLCS.

Current medication, reasons for medication, and dosage:

Medical History Information provided by: Signature: _____ Date: ____/____/____

MEDICAL HISTORY

Is there a family history of:

- | | | | |
|-----------------|-------|-----------------------|-------|
| ' Diabetes | Whom: | ' Cancer | Whom: |
| ' Hypertension | | ' Convulsive Disorder | |
| ' Heart Disease | | ' Mental Illness | |

List below allergies and include the type of allergic reaction to foods, drugs or any other substances:

Does individual wear/use:

- ' Hearing Aid ' Dentures ' Prosthesis ' Eye Glasses ' Other _____

Illnesses: Indicate if the individual has actively had any of the following illnesses:

- | | | | |
|-------------------|----------------------------|-------------------------|----------------|
| ' Chicken Pox | ' Whooping Cough | ' Scarlet Fever | ' Rubella |
| ' Regular Measles | ' Mumps | ' Rheumatic Fever | ' Pneumonia |
| ' Hepatitis | ' Infectious Mononucleosis | ' Meningitis | ' Encephalitis |
| ' Polio | ' Roseola | ' Other Major Illnesses | (List Below) |

Immunizations: Indicate date of most recent immunization and results.

	Date	Results		Date	Results
Polio (oral)	_____		Rubella	_____	
Tuberculin Test	_____		Regular Measles	_____	
Type	_____		Mumps	_____	
Tetanus	_____		Small Pox	_____	
Chicken Pox	_____		Hepatitis B	_____	
Fluogen	_____		Series Given	_____	

Is the individual susceptible to:

- ' Frequent colds
- ' Headaches
- ' Sinusitis
- ' Motor problems
- ' Bronchitis
- ' Stomach aches
- ' Ear infections
- ' Poor posture
- ' Nosebleeds
- ' Ear aches
- ' Foot problems
- ' Weight problems
- ' Sore Throats
- ' Menstrual problems
- ' Chronic cough
- ' Urinary tract infections

From the following list, check those medical conditions which apply and describe complete history below. Include testing, diagnosis and resulting medical/surgical procedures. Use additional page if necessary.

- ' *Seizure Disorder
- ' Psychiatric
- ' Gynecology
- ' Heart/Circulatory Conditions
- ' Dental
- ' Ear, Nose, Throat
- ' Orthopedic (including fractures)
- ' Vision
- ' Other

* If seizure disorder, please describe seizure activity as specifically as possible.

Medical Condition

Tests/Procedures

1. _____

2. _____

3. _____

4. _____

EEG DATE: ____/____/____

RESULTS:

ASSESSMENT OF SKILLS/ABILITIES/INDIVIDUAL CHARACTERISTICS

Scale - Please indicate scale number next to each item below.

- 1 Independent/Yes
- 2 Does with prompts
- 3 Does not complete/No
- 4 Physically unable
- 5 Not Applicable

A. SELF CARE SKILLS

- Brushes Teeth _____
- Washes Face _____
- Takes a Bath/Shower _____
- Uses a Comb/Brush/Pick _____
- Shampoos Hair _____
- Shaves Underarms/Legs _____
- Puts on Deodorant _____
- Cares for Menses _____
- Controls Bowels _____
- Controls Bladder _____
- Is able to Dress _____
- Is able to Undress _____
- Feeds Self _____

- Communicates Needs _____
- Engages in Basic Conversation _____
- Conversation is Relevant _____
- States Day of Week _____
- States the Current Date _____
- Tells Time by the Hour _____
- Tells Time by the Minute _____
- Reads Calendar _____
- Prints Name _____
- Reads Alphabet _____
- Reads Easy Sentences _____
- Reads Difficult Sentences _____
- Reads Rest Room Signs _____
- Identifies Coins _____
- States Value of Coins _____
- Adds Value of Coins _____
- Adds Dollar Denominations _____
- Counts and Identifies 1 - 100 _____
- Writes Numbers 1 - 100 _____
- Uses Community Resources _____
- Understands Danger of Open Flame _____
- Moves Away from Dangerous Heat Sources _____
- Regulates Water Temperature _____
- Identifies Poison Labels _____
- Safely Uses Poisonous Materials _____
- Evacuates During a Fire Drill _____

B. HOME LIVING SKILLS

- Does Laundry _____
- Makes Bed _____
- Puts Clothes in Dresser Drawers _____
- Puts Clothes on Hangers _____
- Cleans Bathroom _____
- Vacuums Rug _____
- Dusts Furniture _____
- Sweeps Floors _____
- Sets Tables _____
- Washes Dishes by Hand _____
- Puts Dishes Away _____
- Operates Kitchen Appliances _____
- Prepares Sandwich _____
- Uses a Knife _____
- Prepares Food from Directions _____

D. MOTOR SKILLS

- Reaches for Object _____
- Picks Up Object _____
- Releases Object _____
- Sits Without Assistance/Support _____
- Stands Without Assistance _____
- Walks without Assistance _____
- Walks Up Stairs without Handrail _____
- Walks Down Stairs without Handrail _____
- Runs _____
- Stands on Tiptoes _____

C. INDEPENDENT LIVING SKILLS

- Walks to Familiar Locations _____
- Crosses Street _____
- Responds to Traffic Light _____
- Communicates Full Name _____

Assessment of Skills/Abilities/Individual Characteristics - Continued

E. PERSONAL & SOCIAL DEVELOPMENT

Scale - Please indicate scale number next to each item below for behaviors that occur or for behaviors that do not occur.

- 1. Yes/Always
- 2. Frequently
- 3. Sometimes
- 4. Rarely
- 5. No/Never

- Is Cooperative _____
- Recognizes Familiar People _____
- Does Physical Violence to Self _____
- Reacts Poorly to Criticism/Frustration _____
- Interacts with Others _____
- Participates in Activities _____
- Is Appropriate with Strangers _____
- Aware of Social Amenities _____
- Threatens Physical Violence _____
- Does Physical Violence _____
- Damages Personal/Others Property _____
- Has Violent Temper/Temper Tantrums _____
- Is Inactive _____
- Uses Hostile Language _____
- Resists Following Instruction _____
- Runs Away/Attempts to Run Away _____
- Takes Others Property _____
- Lies _____

- Is Withdrawn _____
- Has Hyperactive Tendencies _____
- Demands Excessive Attention _____
- Antagonizes Others _____
- Has Stereotyped Behaviors _____
- Excitable _____
- Overactive _____
- Stubborn _____
- Bored at Home _____
- Is Timid with Others _____
- Heedless of Danger _____
- Few Interests _____
- Has no chance to interact with Peers _____
- Prolonged Crying or Giggling _____

- Explanations of any areas above

- Is Afraid of (List Fears)

- Any Traumatic Events; include Individuals Reaction

This concludes the Assessment of Skills/Abilities/Individual Characteristics

FINANCIAL DATA

Source of Income

Monthly

Parent or Guardian	\$	_____
Trust (Trust Amount \$ _____)	\$	_____
Social Security	\$	_____
SSI	\$	_____
State or County Support	\$	_____
Other (List)		
_____	\$	_____
_____	\$	_____
_____	\$	_____

Value

Real Estate Equity	\$	_____
Investments	\$	_____
Annual Household Income	\$	_____
Other Assets:		
_____	\$	_____
_____	\$	_____
_____	\$	_____

Is there a Burial Account for your family member? Yes No
If yes, what is the Amount of the account? _____

Other accounts or assets owned by your family member? (Please list)

_____	\$	_____
_____	\$	_____
_____	\$	_____

Signature: _____

Date: _____

More comprehensive data will be required prior to acceptance.

The information contained herein will be used solely by Martha Lloyd Community Services for the purpose of consideration for admission.

**Health Insurance Portability & Accountability Act (HIPAA)
Authorization Form**

Notice: This Authorization provides for the release of certain records, subject to any restrictions noted below, including; clinical findings, diagnoses, treatment, assessment, recommendations for continued treatment, dates of hospitalization and ambulatory visits, and information that may be related to drug, alcohol, and/or psychiatric conditions. Nonconsensual release of information without Authorization may be allowed under certain circumstances (see 55 Pa Code, Section 5100.32).

I hereby authorize (name/organization/address): _____

To disclose the following information from my health records: _____

For the following purpose(s): Admissions committee review by Martha Lloyd Community Services



Mail



Fax

This information to:

Name: Martha Lloyd Community Services Attn: Admissions
Address: 190 West Main Street Troy PA 16947
Telephone: (570) 297-2185 ext 268 Fax: _____

I hereby acknowledge that the above health information may be used or disclosed only until (enter specific date or event relating to the purpose for the use or disclosure): Conclusion of admission review

I hereby acknowledge and understand that treatment is NOT conditioned upon my signing of this Authorization. I hereby acknowledge that I have the right to refuse to sign this Authorization, if I so choose. I understand that I have the right to revoke this Authorization at any time. Such revocation must be submitted in writing to the Privacy Officer at Martha Lloyd Community Services Troy, PA 16947. This revocation will become effective immediately upon receipt, except to the extent that action has already been taken in reliance of this Authorization.

I acknowledge that I have been informed and understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure and, at that point, the information may no longer be protected under the terms of this Authorization agreement.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS AUTHORIZATION, AND AFFIRM THAT I AM THE PERSON, OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PERSON, TO SIGN THIS FORM VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE TERMS.

Signature

Date

Print Full Name

Signature of Personal Representative

Date

Print Full Name

If individual is unable to sign and verbal authorization is granted, two (2) witness signatures are required.

Signature of Witness and Date

Signature of Witness and Date

Note: It is our policy to only release information created by this organization. Federal law may prohibit the person/entity receiving information pursuant to this Authorization from making any further disclosure unless expressly permitted by written authorization of the person to whom the information pertains, or as otherwise permitted by 42 C.F.R. Part 2.

