# NEXT STEP DAY SERVICES PROGRAM APPLICATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alt Phone: _____

Date of Birth: _____ Social Security Number: _____

Does the participant live: _____ At home with parents/caregiver

_____ In a Supported Living/Assisted Living home

Primary Diagnosis: _____

**Services Requested: (mark all that apply)**

____ Community Based Services ____ On Site Services

____ Work/Supported Employment Services ____ Volunteer Opportunities

____ Community ____ Other (please explain below)

_____

_____

_____

**Descriptive Information**

Height: _____ Weight: _____ Sex: M F

Is this individual legally competent? Yes No

**Parent / Conservator Information**

Name(s): _____

Address: (indicate if same as above) _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Participant's Name: _____ ***2***

**First Emergency Contact**

Name: _____

Relationship to participant: _____ Phone: _____

**Second Emergency Contact**

Name: _____

Relationship to participant: _____ Phone: _____

**Activities**

| | | |
|---|---|---|
| Attends church | Yes____ | No____ |
| Shops with supervision | Yes____ | No____ |
| Shops without supervision | Yes____ | No____ |
| Can make simple cash transactions | Yes____ | No____ |
| Manages sums of money | Yes____ | No____ |
| Amount applicant can manage $_____ | | |
| Walks independently in own yard | Yes____ | No____ |
| Walks independently in neighborhood | Yes____ | No____ |
| Walks independently more than one mile with supervision | Yes____ | No____ |
| Can self-feed with supervision | Yes____ | No____ |
| Enjoys going out to eat | Yes____ | No____ |
| Goes to the movies | Yes____ | No____ |
| Watch TV | Yes____ | No____ |
| Can use DVD with supervision | Yes____ | No____ |
| Plays games independently | Yes____ | No____ |
| Plays games w/ others | Yes____ | No____ |
| Reads | Yes____ | No____ |
| Writes | Yes____ | No____ |
| Operates the radio | Yes____ | No____ |
| Enjoys crafts | Yes____ | No____ |

Any additional comments or information regarding this applicant? _____

Participant's Name: _____ ***3***

**Medical History**

Does applicant have a current physical (within the last 12 months) If Yes, please attach. If No, one is required to attend Day Program.

Has applicant ever had a seizure? Y___ N___ **If Yes, please indicate at what age seizure began**. _____

Does applicant continue to have seizure like activity? Yes_____ No_____

**If YES, how frequent? _____**

Does the applicant require mobility equipment/specialized appliances? (Ex: wheelchair) Yes ___ No ___

If YES, please list type and purpose. _____

Does the applicant have a history of behaviors? Yes ____ No ____ If YES, please describe behaviors __

_____

_____

**Medical Information**

MR Level: *circle which applies* Mild Moderate Severe

Competency Status: *circle which applies* Competent Incompetent

Other Disabilities / Diagnoses: _____

Allergies: (food, drug, environmental, etc.) _____

**Please indicate severity of above allergy** (if any): _____

Specialized diet? Yes____ No ____ If YES, please explain_____

Severity of allergy (medical attention required?) Yes____ No____

**Physician Information**

Name: _____ Phone: _____

Clinic / Hospital: _____

Address: _____ City: _____ State: _____ Zip: _____

Participant's Name: _____ ***4***

**Medication history of applicant (include both prescription and any over the counter medication) *use the back of this page if more room is needed**

| DRUG | FREQUENCY | ROUTE | TIME |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

**Other Specialists**

Name: _____ Phone: _____

Clinic / Hospital: _____

Address: _____ City: _____ State: _____ Zip: _____

**Support Coordinator**

Name: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____

**OVER THE COUNTER MEDICATION AUTHORIZATION FORM**

Employee/Program Participant: _____

DOB: _____

Department of Mental Health requires a written medical authorization by a Health Care Provider (physician, nurse practitioner, PA, etc.) to provide first aid and/or administer over-the-counter medication for minor medical needs. This does include medications such as ibuprofen, acetaminophen, cough drops, triple antibiotic ointment, etc.

_____Tylenol/Acetaminophen Reason: _____

Dosage: _____ Frequency: _____

_____Ibuprofen Reason: _____

Dosage: _____ Frequency: _____

_____Benadryl/Antihistamine Reason: _____

Dosage: _____ Frequency: _____

_____Medication: _____ Reason: _____

Dosage: _____ Frequency: _____

Please check all treatments below that you approve for First Aid Care for the Employee/Program Participant. For minor cuts/abrasions/insect stings/burns/muscle aches, the following may be applied:

_____ Triple Antibiotic Ointment _____ Hydrocortisone 1% Cream _____Sterile eye drops

_____ Burn Free Pain Relieving Gel _____ Sterile eye drops _____ Cough drops

_____Other_____

_____

PHYSICIAN PRINTER NAME PHYSICIAN SIGNATURE DATE

_____

PHYSICIAN ADDRESS PHYSICIAN PHONE NUMBER