APPLICATION FOR SERVICES

Type of Service being applied for:
_____ MHC (Geneva) _____ MPC (Bloomingdale) _____ MWC (Elgin)
_____ Residential (ICF/CILA/MCDD) _____ Day Program

Name of Client:_____ Birthday _____ Sex: Male___ Female____
(M/D/YYYY)
Street Address _____ City, State _____ Zip Code _____

Township_____ County_____ Citizen of U.S.A: Yes_____ No_____

Birthplace _____ Religion _____
(City/State/Country)
Race:_____
(White, African American, Hispanic, Native American, Asian, Pacific Islander, African American & White, Asian & White)
(Clients are never discriminated against, regardless of race, age, color, ancestry, creed, sex or handicap)

Primary Language Spoken/Understood:_____ Has Client Attended School: ____Yes ____No

Highest Level of Education:_____
School Name: _____ School District:_____
Has Client received: Diploma: _____Certificate of Completion:_____

Attends Day Program: _____Yes _____No Program Name:_____

Insurance Coverage:
Client's Public Aid Numbers: Case # ____ ____ ___ _____ Public Aid Recipient ID# _ _ _ _ _ _ _ _ _
Enrolled with Integrated Care Program: IlliniCare_____ Aetna Better Heath_____
Social Security Number: _____ - ___ - _____ DCFS/DMH Identification # _____

Does Client receive Social Security: Yes _____ No _____ On what SS Number: _____ ____ _____

Social Security Supplemental Income (SSI):Yes _____ No _____

Medicare: Yes _____ No _____ Medicare Number: _____
Private insurance: Yes _____ No _____

If yes, Name of company_____

Street Address _____
(City, State, Zip Code)

Policy Holder Name: _____

Policy Number _____ Group Number:_____

Client receive Home Based Support from Dept. of Human Services: Yes _____No _____ If not, is there another funding source: _____

Does the Client have a trust fund: Yes_____ No_____
Who is financially responsible for the Client's care: _____

Have Marklund services been used before: Yes_____ No_____ If yes, when were services utilized and what type of services:_____

Parent/Guardian:

Father:

Name:_____ Street Address _____

City, State _____ Zip Code _____ Telephone (____)_____

DOB _____ Birthplace _____
(M/D/YYYY) (City/State/Country)

Cell Phone (____)_____ e-mail _____

Occupation _____ Employer Address_____

Work #(____)_____ S.S.# _____ - ___ - _____ Highest Level Of Education:_____

Parent Marital Status: Married____ Separated___ Divorced____ Widowed____ Single____

Mother:

Name: _____ Street Address _____

City, State _____ Zip Code _____ Telephone (____)_____

DOB _____ Birthplace _____
(M/D/YYYY) (City/State/Country)

Maiden Name _____

Cell Phone (____)_____ e-mail _____

Occupation _____ Employer Address_____

Work(____)_____ Mother's S.S.# _____ - ___ - _____ Highest Level Of Education:_____

Court Appointed Guardian (if client is over 18): Father____ Mother____ Other (DCFS, OSG)_____

Other:

Name: _____

Address _____ City, State _____ Zip Code _____

County _____ Township:_____ Home Telephone (____)_____Work# (____)_____

Cell Phone (____)_____ e-mail _____

With whom does the Client live: Mother _____ Father _____ Guardian _____ Other_____

If other, Name and Address _____
Relation:_____

What is the best way to contact Guardian? ( ) Home Phone ( ) Cell Phone ( ) E-Mail

Siblings	Sex	Birthdate	Live with Parent
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

If Any Siblings Deceased, Name, Age At Death And Cause

_____

_____

_____

Guardian Household Size:_____

Guardian Annual Household Income (estimate or exact):_____

Emergency Contacts:

Name:_____ Relation:_____Home Ph:_____

Cell Ph:_____

Name:_____ Relation:_____Home Ph:_____

Cell Ph:_____

MEDICAL:

Primary Diagnosis_____ Age at Onset _____

Diagnosis Caused By:_____

Other Moderate to Severe Chronic Medical Conditions _____

Level of Disability: Mild _____ Moderate _____ Severe _____ Profound _____

Epilepsy/Seizure Disorder Yes _____ No ____ Controlled _____Uncontrolled _____

How often, if yes_____ Describe_____

_____

Immunizations up to date? ____Yes ____No

Medications name, dosage & times (attach list if necessary):

_____

_____

_____

_____

_____

Hospitalizations: (Last 5 years)

Hospital: _____ Reason: _____ Length of Stay:_____

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Hospital: _____ Reason: _____ Length of Stay:_____

Allergies: ___ Yes ___No

If yes, to what and what is the reaction:

_____

_____

Intolerances: __Yes __No

If yes, to what and what is the reaction: _____

_____

Equipment Needs:

Apnea Monitor ___ Trach ___ Suctioning____, Frequency_____
Cardiac Monitor ___ Moisture___
Nebulizer ___ Oxygen___, Liter Flow_____

Are there any reasons why Client cannot participate in:
Habilitation Program: ___ Yes ___No
Therapeutic Community Outings ___Yes ___No

What are the reasons why Client cannot participate: _____
_____
_____

Communicable Diseases: (What communicable diseases has client had & when)

Communicable/Contagious Disease	Year
_____	_____
_____	_____
_____	_____

NUTRITIONAL:

Client's Weight: _____ Client's Height: _____
Diet Consistency: _____Pureed _____Mechanical Soft ____Regular
Liquid Intake Method: ____ Cup ____Bottle ____N/G ____Gastrostomy
Type of Gastrostomy Tube: ____Mickey ____Janeway ____Foley
Type of Formula: _____
How often is G-tube changed: _____
Does Client have episodes of vomiting: ____No Yes____ How Often: _____

Eating Habits (describe, i.e., special sitting arrangements, special tools, etc.):
_____
_____
_____

Intolerances:_____
_____
_____

DEVELOPMENTAL:

Cognitive Level of Functioning: _____

Adaptive Skills Level of Functioning: _____

___Ambulatory	___Non-ambulatory
___Mobile	___Non-mobile
___ Self Feeds	___Must be fed
___Sits by self	___Cannot sit
___Pulls up to stand	___Cannot pull self up
___Crawls	___Does not crawl
___Rolls Over	___Cannot roll over
___Drinks by Cup	___Needs assistance with cup
___Vision Good	___Blind/legally blind/vision deficits
___Hears well	___Deaf/Hearing deficits

___Needs protective device on bed (describe): _____

Mode of Transportation:
Wheelchair: ____Self-propel ___Non-self propel ____Other: _____
Wheelchair stabilizers: ____Pelvic ___Feet ___Chest ___Head ____Specialized Seating
____Custom Inserts ____Brakes _____Busing Ties

ORTHOPEDIC:
Are there any contractures: Yes___ No___
If so, where: _____

Muscle Tone: ____Spastic ____Normal ____Hypotonic
Have there been any orthopedic surgeries: ___Yes ___No

Surgery Date Outcome

_____
_____
_____
_____

PSYCHO/SOCIAL/HISTORY:
Awareness of:
___Peers ____Environment ____Adults
Responds to:
____Silent Smile ____Verbal greeting _____ Tactile
Localizes to:
____Voices ____Environmental sounds _____Visual Stimuli
Communication Device (Picture book, talking device, iPad, singing):

_____

Behaviors:

___No behavior problems
___Potential behavior problems (check all that apply):
____Bites self ____Bites others ___Consistent screaming
____Scratches self ____Scratches others ___Repetitive behaviors
____Pinches self ____Pinches others ___Putting non-food items in mouth

Other (specify)_____
_____
_____

Interventions used to stop behavior: _____
_____
Are the methods successful: ___Yes___No

Likes (Describe):_____
_____
_____

Dislikes (Describe):_____
_____
_____

3 Interesting/Neat Facts about the Client (i.e. favorite color, hidden talent, favorite subject.):_____

Sleeping Habits (Describe):_____

Birth History: Was pregnancy & delivery normal, birth weight, was disability noticed at birth, did client come home from hospital with parent/guardian or did he/she remain hospitalized? At what age was client discharged from hospital? Where was client discharged to following birth? What nursing care was necessary? Any other pertinent events occur at birth?

Developmental History: Achievements: Age first sat, rolled, crawled, and walked independently. If milestones reached, age client ceased doing them. If any accident occurred that caused the disability, what happened and at what age?

Employment/Developmental Training History: Has client had employment opportunities? What developmental training skills has client acquired?

What has prompted the need for Marklund services? What are the feelings about this decision?

_____
_____
_____
_____

I understand that, Marklund provides residential and day training services for individuals with developmental disabilities. Marklund will accept and provide skilled nursing care (Bloomingdale and Elgin locations) providing that Marklund's admission criteria is met.

All prospective Clients must be evaluated by Marklund interdisciplinary team (IDT). Prior to admission or being placed on A waiting list.

Applicants are not discriminated against, regardless of race, age, color, national ancestry, creed, sex or condition.

_____

_____	_____	_____	
Person Completing Form	Relation to Client	Signature	Date

Return this completed Application to:

Natalie Rubino
Social Service Manager
Marklund
1S450 Wyatt Dr.
Geneva, IL 60134

P: (630) 593-5484
nrubino@marklund.org