APPLICATION FOR SERVICES

TYPE OF SERVICE REQUESTED (CHECK ALL THAT APPLY):

Residential: _____ICF/DD (Geneva) _____MCDD (Bloomingdale / Elgin) _____CILA

Day Program: ______ (Geneva) ______ (Bridge Builder – Elgin)

PERSONAL INFORMATION:

Name of Individual: ________________________ Birthday: ____________ (M/D/YYYY) Sex: ________

Street Address: ________________________ City: ____________________

State: ____________ Zip Code: ____________ Township: ____________________

County: ________________________ Citizen of USA: ____ Yes ____ No

Birthplace: ________________________ (City/State/County/Country) Religion: ____________________

Race: ________________________ (White, African American, Hispanic, Native American, Asian, Pacific Islander) Primary Language Spoken/Understood: ____________

Individuals are never discriminated against based on race, age, color, ancestry, creed, sex, or disability.

SCHOOL / DAY PROGRAMMING INFORMATION:

Has Individual Attended School: ____ Yes ____ No

School Name: ________________________ School District: ____________

Highest Level of Education: ____________; Received: ____ Diploma ____ Certificate of Completion

Does Individual Attend a Day Program: _____Yes _____No

Program Name: ________________________ Program Location: ____________

INSURANCE / FUNDING / FINANCIAL INFORMATION:

Medicaid Recipient ID Number (RIN): ____________ Enrolled in Managed Care Program: ____Yes; ____ No.

If yes, name of program: ________________________

Social Security Number: ____________; Does Individual Receive Social Security: ____ Yes; ____No.

Does Individual Receive Social Security Supplemental Income (SSI): ____ Yes ____ No

Does Individual Have Medicare: ____Yes; ____ No. If yes, Medicare Number: ____________

Does Individual Have Private insurance: ____ Yes ____ No

Name of Company: ________________________

Address: ________________________ (Street, City, State, Zip Code)

Policy Holder Name: ____________________

Policy Number: ____________________ Group Number: ____________________

Does Individual Receive Home Based Support from Dept. of Human Services: ____ Yes ____ No. If no, is there another funding source: ____________________

Does the Individual have a trust fund: ____ Yes ____ No

Who is financially responsible for the Individual's care: ____________________

FAMILY / GUARDIAN INFORMATION:

Father's Name: ____________________ Street Address: ____________________

City: ____________________ State: ____________________ Zip Code: __________

Home Phone: ____________________ Cell Phone: ____________________

DOB: ____________________ Birthplace: ____________________
(M/D/YYYY) (City/State/Country)

E-mail Address: ____________________

Occupation: ____________________ Employer Address: ____________________
(Street, City, State, Zip Code)

Work Phone: ____________________ S.S.#: ____________________ Highest Level of Education: __________

Mother's Name: ____________________ Street Address: ____________________

City: ____________________ State: ____________________ Zip Code: __________

Home Phone: ____________________ Cell Phone: ____________________

DOB: ____________________ Birthplace: ____________________
(M/D/YYYY) (City/State/Country)

E-mail Address: ____________________

Occupation: ____________________ Employer Address: ____________________
(Street, City, State, Zip Code)

Work Phone: ____________________ S.S.#: ____________________ Highest Level of Education: __________

Parent Marital Status: Married____; Separated___; Divorced____; Widowed____; Single____

Court Appointed Guardian (if over 18): ____ Father ____ Mother ____ Other (DCFS, OSG, relative, etc.). If other:

Guardian Name(s): ____________________ Relation to Individual: ____________________

Street Address: ____________________

City: ____________________ State: ____________________ Zip Code: __________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Email Address: ____________________

With Whom Does the Individual Reside: ____________________

What is the best way to contact Parent/Guardian: ____Home Phone; ____Cell Phone; ____E-mail

Siblings	Sex	Birthdate	Live with Parent (Y / N)
____________________	______	__________	__________
____________________	______	__________	__________
____________________	______	__________	__________
____________________	______	__________	__________

If Any Siblings Deceased: Name, Age at Death, and Cause

____

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Guardian Household Size (total number of people living in the residence): __________

Guardian Annual Household Income (exact or estimated): ______________________

EMERGENCY CONTACT INFORMATION: (*Provide names & contact info for people we can contact in the event that we cannot reach you)*

Name: ______________________________ Relation: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________

Name: ______________________________ Relation: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________

MEDICAL INFORMATION:

Primary Diagnosis: ______________________________ Age at Onset: __________

Diagnosis Caused By: ______________________________________

Other Diagnoses and/or Moderate to Severe Chronic Medical Conditions: ______________________

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Level of Disability: ____ Mild; ____ Moderate; ____Severe; ____Profound

Epilepsy/Seizure Disorder: ____Yes; ____ No. If yes, ____Controlled; ____ Uncontrolled

Frequency: ____

Describe: ____

____

Immunizations Up-to-Date: ____Yes; ____ No

Medications (names, dosages, times – attach list if necessary): ______________________

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Has the Individual been hospitalized in the last 5 years: ____Yes; ____ No. If yes, please list:

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: ______________________________

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____

Medical Equipment Needs (check all that apply):

____ Apnea Monitor; ____ Tracheostomy; ____ Suctioning (Frequency: ______________________)

____ Cardiac Monitor; ____ Moisture; ____ Nebulizer; ____ Oxygen (Liter Flow: __________________)

____ Ventilator (Frequency/Settings: ____)

Are There Any Reasons Why Individual Cannot Participate in:

Habilitation Program: ____Yes; ____No Therapeutic Community Outings: ____Yes; ____No

If yes, reasons why: ____

____

____

Communicable Diseases: ___ Yes ___No. If yes, list which one(s) & when: ______________________________

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NUTRITIONAL INFORMATION:

Individual's Weight: _______ lbs; Individual's Height: _______

Diet Order: ____Oral Feedings; ____NPO; ____Pleasure Feedings

Diet Consistency: ____Pureed; ___Regular; ____Mechanical Soft

Liquid Intake Method: ____Cup; ____Bottle; ____Nasal Gastrostomy Tube; ____Gastrostomy Tube

Type of Gastrostomy Tube: ____ Mickey; ____ Janeway; ____Foley

How often is g-tube changed: __________________; Type of Formula: ______________________________

Does Individual have episodes of vomiting: ____Yes; ____No. If yes, how often: ______________________

Please describe eating habits (i.e., special sitting arrangements, special tools, etc.): __________________

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____

____

Intolerances: ____

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____

DEVELOPMENTAL INFORMATION:

Cognitive Level of Functioning: ____

Adaptive Skills Level of Functioning: ____

Please check all that apply:

____ Ambulatory	____ Non-Ambulatory
____ Mobile	____ Non-Mobile
____ Self-Feeds	____ Must Be Fed
____ Sits by Self	____ Cannot Sit
____ Pulls Self to Stand	____ Cannot Pull Self Up to Stand
____ Crawls	____ Does Not Crawl
____ Rolls Over	____ Cannot Roll Over
____ Drinks by Cup	____ Needs Assist with Cup
____ Vision Good	____ Blind / Legally Blind / Vision Impairment
____ Hears Well	____ Deaf / Hearing Impairment
____ Verbal	____ Non-Verbal
____ Protective Devices on Bed	____ Does Not Need Protective Devices on Bed

If protective devices are needed on bed, please describe: ____

____

EQUIPMENT INFORMATION:

Wheelchair: ____Self-Propel; ____Does Not Self-Propel; ____Motorized

Wheelchair Stabilizers/Harnesses (check all that apply):

___Pelvic; ____Feet; ___Chest; ____Head; ____Specialized Seating; ____Custom Inserts; ____Brakes; ____Busing Tires

Communication Device: ____ Yes; ____ No. If yes, please describe (i.e., iPad, Picture Book, Talking Device, etc.): _______

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ORTHOPEDIC INFORMATION:

Are there any contractures: ____Yes; ____ No. If yes, where: ____

____

Muscle Tone: ____Spastic; ____Normal; ____Hypotonic

Have there been any orthopedic surgeries: ___Yes; ___No. If yes, please list below:

Type of Surgery	Surgery Date	Outcome
____________________	__________	__________
____________________	__________	__________
____________________	__________	__________
____________________	__________	__________

PSYCHOSOCIAL / BEHAVIOR INFORMATION:

Awareness of: ____Peers ____Environment ____Adults

Responds to: ____Silent Smile ____Verbal greeting ____Tactile

Localizes to: ____Voices ____Environmental sounds ____Visual Stimuli

Behaviors: ____ Yes; ____ No. If yes, check all that apply:

____Hurtful to self ____Hurtful to others ____Loud Vocalizations ____Property Destruction

____Elopement ____Repetitive behaviors ____Stealing/Theft

____Putting non-food items in mouth ____Other

Please describe in detail: ____

____

____

Interventions used to stop behavior: ____

____

____

____

Are the methods successful: ____ Yes; ____ No

Does the individual currently have a Behavior Support Plan: ____ Yes; ____ No

Likes: ____

____

____

Dislikes: ____

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____

Sleeping Habits: ____

____

GENERAL INFORMATION:

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

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____

Developmental History: (i.e., Age first sat, rolled, crawled, walked independently, etc. If milestones were reached, age when individual ceased doing them. If any accident occurred that caused the disability, what happened and at what age?)

Employment/Developmental Training History: (Has the Individual had employment opportunities? What developmental training skills has the Individual acquired?)

Have Marklund services been used before: ____ Yes; ____ No. If yes, when were services utilized and what type of services:

What has prompted the decision to apply for Marklund services? What are your feelings about this decision?

Please indicate when you may be interested in placement:
____ Immediately; ____ in 1-3 years; ____ in 3-5 years; ____ in 5+ years

Have you been in contact with a Service Coordination/Placement Agency (i.e., Service, Inc. of Illinois, Community Alternatives Unlimited, etc.): ____ Yes; ____ No. If yes, please indicate which agency and provide a contact name: ______________

How did you hear about Marklund?

I understand that Marklund provides residential and adult day training services for individuals with developmental disabilities. Marklund will accept and provide care for the individual provided that Marklund's admission criteria is met. All prospective residents and adult day training clients must be evaluated by the Marklund Interdisciplinary Team (IDT) prior to admission or being placed on the waiting list.

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

Person Completing Form (please print)	Relation to Individual
Signature	Date

Return this completed application to:

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

P: (630) 593-5484
F: (630) 397-5635
nkleba@marklund.org