Community Visions, LLC.
Application for Admission

COMMUNITY VISIONS, LLC.
BROADENING HORIZONS AND EMBRACING NEW DREAMS

SIS Information:
Date:_____
Level: _____
Tier: _____

Please complete the application in full. If you are submitting an attachment, please indicate the attachment name and page number where information to the questions below can be found. If a question does not apply, please indicate N/A.

Please select service(s) for referral:

Specific Program/Location ▢Life ▢ Explorations ▢Charming Concepts

Has the applicant previously applied for services? If yes, when? Date: _____ No _____

Personal/Health Information

Name: _____ Gender: ____ Age: ___ Date of Birth: _____

Current Address: _____
(Street) (City, State) (Zip)

Phone Number:_____

Social Security #:_____ U.S. Citizen: _____

Legal Status (own guardian?):_____ (If yes, has a capacity evaluation been completed?) Date: _____

Primary Language: _____

Parent(s):

Name: _____

Address: _____
(Street) (City, State) (Zip)

Home #: _____Cell #: _____

Email Address: _____

Name: _____

Address: _____
(Street) (City, State) (Zip)

Home #: _____Cell #: _____

Email Address: _____

Sibling(s)/Significant Others: N/A

Name: _____ Relationship: _____

Address: _____ Phone Number: _____
(Street) (City, State) (Zip)

Name: _____ Relationship: _____

Address: _____ Phone Number: _____
(Street) (City, State) (Zip)

Other Contact Information:

Legal Guardian/Authorized Representative: _____

Relationship: _____

Address: _____
(Street) (City, State) (Zip)

Home #: _____ Cell #: _____

COVID-19

Has the applicant been fully vaccinated against COVID-19? YES_____ NO_____

**The COVID-19 vaccine is required for admissions into the CV program. Please attach the vaccination record to this application*

Legal:

Has the applicant been charged or convicted with any crimes? _____

If so, please list each charge or conviction :

Charge/Conviction	Date of Charge/Conviction	Class (Misd./Felony?)	Disposition/Outcome

Power of Attorney (Healthcare, Financial): _____

Contact Information: _____

Advance Directive: (if applicable, please attach copy): _____

Support Coordinator: _____ Phone Number: _____

Referring CSB: _____ Fax Number: _____

Address: _____

Email: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____
(Street/Suite) (City, State) (Zip)

Current Diagnoses:

_____

_____

Reason for Services/Application:

_____

_____

_____

Please List the Dates Received for the Following Vaccinations: *(*The following Vaccines are required for admissions into the CCI program. please attach medical record as applicable)*

Td/Tdap Tetanus, Diphtheria, Pertussis (recommended every 10 Years)	**Pneumococcal**	**MMR Measles, Mumps, Rubella**	**HPV for Women** (for women entering 6th grade after 2008/may not apply)	**Chickenpox**	**Hepatitis B**

Consulting Physicians: (Cardiologist, Psychiatrist, Dermatologist, Neurologist, Dentist, Etc.)

Name	Specialty	Phone Number

History of Applicant (including current status):

	Dates	Hospital/Institution	Attending Physician	Type of Treatment
Previous Incarceration				
Mental Illness/ Psychiatric Treatment				
Alcohol or Drug Abuse				
Infectious Diseases (MRSA, HIV, Hepatitis, TB, etc).				
Other Hospitalizations				

Medications: List all medications **currently** being taken (use additional pages as necessary).

Medication	Dosage	Frequency	Indication	**Medication**	Dosage	Frequency	Indication

None (no meds							

Previously Taken Medications (Does not apply to collaborations)

Medication	Dosage	Frequency	Indication	**Medication**	Dosage	Frequency	Indication
None							

Present Conditions:

Ambulation	**Impairments**	**Special Precautions**	**Individual Has:**
___ Independent	___Vision	___ Aggression	___Dentures
___Wheelchair	___Hearing	___ Chokes easily	___Eyeglasses
___Cane/Walker	___Speech	___ Hides Medications	___Hearing Aid
___Unsteady Gait	___Bowel/Bladder	___ Wanders	___Braces/Splints
		___ Elopes	___Other_____
		___ Other_____	

List and Purpose of Any Adaptive Equipment Not Otherwise Specified:

_____

History of Illnesses/Injuries: _____

Date of Last Psychological Evaluation (please attach a copy): _____

Additional Comments Related to Medical/Healthcare:

_____

_____

Drug Contraindications/Allergies: _____

Food Allergies: _____

Self-Care Capabilities:

Self Care Capability	Independent	Verbal Prompt	Physical Prompt	Total Assistance
Washing face and hands				
Bathing				
Hair Care				
Nail Care				
Shaving				
Brushing teeth and/or dentures				
Toileting				
Dressing/Undressing				
Feeding Abilities				
Use of Public Transportation				
Self Medication				
Food Preparation				

Communication:

☐ Verbal ☐ Vocalizations ☐ Gestures ☐ Signs ☐ Communication Device(s):

Describe how individual interacts with others:

_____

_____

_____

_____

Describe the best way to interact with the individual:

_____

_____

_____

_____

Likes, Dislikes or Preferences of the Individual:

_____

_____

_____

_____

Is Individual Involved in Any Regular Community Activities: Enjoys attending community activities.

_____

_____

_____

_____

Behavior Supports:

Does Individual currently/previously have a **Behavior Supports Plan**? Yes___ No ____

Name of Consultant: _____ Company: _____

Phone Number: _____

Current Placement:

☐ Family Home ☐ Residential Group Home:_____ ☐ Other: _____

Group/Other home contact info: _____

☐

☐ Day Support: _____ ☐ School: _____ Other: _____

Financial Information:

Waiver: ___DD Waiver
___Other Funding Source (please specify): _____

Income:	Source	Amount
	SSA_____	_____
	SSI _____	_____
	SSDI _____	_____
	Wages_____	_____
	Other_____	_____

Medical Insurance:

_____ Medicaid # _____

_____ Medicare # _____

_____ Other # _____

Policy #: _____

Signature: _____ Date: _____

Title: _____

For Office Use
Application Received: _____Application _____Accepted _____Rejected _____Waiting List_____
(DATE)

Date Letter Sent_____ Admission Date: _____