Unending Possabilities

P.O. Box 1629 Van, TX 75790 unendingpossabilities@juno.com

APPLICATION FOR ADMISSIONS

Thank you for your interest in Unending Possabilities. Please complete and return the following items:

Application
Medical History
Release of Information
Application Fee of $50.00 (nonrefundable)
Recent family photo and individual photo

A thorough answer to all questions is essential. In addition to these forms, we need copies of the applicant's most recent educational, psychological, and psychiatric evaluations (if available) as well as any other information that would be helpful in determining whether Unending Possabilities can meet this individual's needs.

The Admissions Committee conducts a thorough study of the information provided, determines the placement availability and suitability of each applicant, and notifies you whether or not to continue with the next step in the application process. If you have any questions, please do not hesitate to call 903-714-3123.

All applicants must be age 20 or older.

Unending Possabilities Considers All Applicants Regardless of Sex, Race, Religion, or Ethnic Origin.

Date Placement Desired _____ Location_____

Applicant's Full Name | Date of Birth

Street Address | City | State | Zip

( ) Telephone | Social Security Number | Height | Weight | Sex

Mother's Name | Home Email Address | ( ) Home Telephone #

Home Address | City State Zip | Cell Phone #

Occupation / Name of Company | Bus. Email Address | ( ) Business Telephone #

Father's Name | Home Email Address | ( ) Home Telephone #

Home Address | City State Zip | Cell Phone #

Occupation / Name of Company | Bus. Email Address | ( ) Business Telephone #

Legal Guardian | Relationship

Home Address | City | State | Zip

Occupation / Name of Company Email Address (Home and/or Business)

( ) ( ) ( )

Home Telephone # Business Telephone # Cell Phone #

Names and ages of applicant's siblings:

Please indicate the person or agency that referred you to Unending Possabilities:

SCHOOLS OR PROGRAMS ATTENDED

CHECK ALL SITUATIONS IN WHICH THE APPLICANT HAS PARTICIPATED.

_____ Day School

_____ Sheltered Workshop

_____ Group / Family Care Home

_____ Independent Living Situation

_____ Competitive Employment

_____ State School

_____ Private School

_____ Other, (Explain)

PLEASE COMPLETE THE FOLLOWING INFORMATION ON EACH PROGRAM: (Please use the back of this page if more space is needed.)

1) _____

Name Dates

_____

Address City State Zip

Type of Situation (Refer to list at top of page)

Reason for Leaving

Person to Contact for More Information

2)

Name Dates

Address City State Zip

Type of Situation (Refer to list at top of page)

Reason for Leaving

Person to Contact for More Information

3)

Name Dates

Address City State Zip

Type of Situation (Refer to list on previous page.)

Reason for Leaving

Person to Contact for More Information

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) Please describe applicant's diagnoses, general health, including special medical problems and/or physical disabilities:

_____

_____

_____

2) Please describe applicant's communication abilities:

_____

_____

_____

3) Please describe applicant's social/emotional state most of the time (for example: withdrawn, hyper-verbal, frustrated, sociable, even-tempered, etc.):

_____

_____

_____

4) Does he/she prefer to be with peers, family, someone older, younger, or alone? Please explain:

_____

_____

_____

5) Please describe applicant's self-help skills (What does someone need to do daily to help the applicant?).

_____

_____

_____

6) Please describe applicant's daily routines and leisure (free time) activities:

_____

_____

_____

7) What do you see to be the applicant's functional disabilities?

_____

_____

_____

8) What do you think applicant feels are his/her disabilities?

_____

_____

_____

9) What are the applicant's specific aptitudes, interests, and/or strengths?

_____

_____

_____

10) Has the applicant ever been involved with any of the following?

	Yes	No
Tobacco	_____	_____
Drug Abuse	_____	_____

Criminal Activity	_____	_____
Sexual Misconduct	_____	_____

If yes, please explain:

_____

_____

11) Please describe activity areas and/or situations that the applicant strongly dislikes:

_____

_____

12) How does the applicant respond to situations they don't like or that upsets them?

_____

_____

13) Has the applicant ever exhibited behaviors such as hitting, yelling, throwing, biting, or making verbal threats, etc.? If so, what seems to trigger these behaviors?

_____

_____

14) Please describe activity areas and/or situations that the applicant enjoys:

_____

_____

15) Please describe your goals and expectations for the applicant and what you hope UP can accomplish:

_____

_____

16) References: Please list three (3) individuals whom we may contact (different from those listed on page 4-5) who have worked with or known the applicant closely.

1) _____ ( ) _____ ( ) _____
Name Home Telephone Cell Phone #

_____
Address City State Zip

_____
Email Relationship to applicant

2) _____ ( ) _____ ( ) _____
Name Home Telephone Cell Phone #

_____
Address City State Zip

_____
Email Relationship to applicant

3) _____ ( ) _____ ( ) _____
Name Home Telephone Cell Phone #

_____
Address City State Zip

_____
Email Relationship to applicant

MEDICAL HISTORY

Name of applicant's primary physician:

_____ Telephone (____) _____

_____

Address City State Zip

Please list any other specialists who have treated or are treating the applicant:

_____

_____

_____

_____

Is applicant on any regular medications? ☐ YES ☐ NO
If yes, please list below: (If more space is needed, use separate piece of paper and attach.)

Medication	Dosage/Frequency	Prescribed By	Reason Prescribed

ALLERGIES/RESTRICTIONS

Is applicant allergic to any medications? If yes, please list:

_____

_____

Is applicant allergic to foods, pollens, insect bites, skin contacts, substances, etc? If yes, please describe reaction and what treatment is usually necessary:

_____

_____

Does applicant have any dietary restrictions? If so, please list:

_____

_____

_____

If on any medication/injection for allergies, please give name of medication/injection, dosage and frequency:

_____

Prescribed by: _____

HISTORY OF ILLNESS/HOSPITALIZATION/SURGERY

Has applicant had more than a brief illness during the past three year? ☐ YES ☐ NO

If yes, when? _____

Describe _____

_____

Name of attending physician: _____

Has applicant ever been hospitalized? ☐ YES ☐ NO

If yes, when? _____

Describe: _____

Please list hospital and address: _____

_____

City State Zip Code

Has applicant had any surgeries? ☐ YES ☐ NO

If yes, when? _____

Describe: _____

Please list hospital and address: _____

_____

City State Zip Code

HEALTH HISTORY

If the applicant is prone to (or has had) problems with any of the following, please indicate YES or NO. If YES, explain in space provided. Also, list preferred treatment, if applicable. If extra space is needed, use separate piece of paper and attach.

Cold/Sinus Trouble	☐ YES	☐ NO	_____
Headaches	☐ YES	☐ NO	_____
Eyes	☐ YES	☐ NO	_____
Glasses	☐ YES	☐ NO	_____
Ears	☐ YES	☐ NO	_____
Hearing	☐ YES	☐ NO	_____
Chest Infections	☐ YES	☐ NO	_____
Asthma	☐ YES	☐ NO	_____
Epilepsy/Seizures	☐ YES	☐ NO	_____
Tuberculosis	☐ YES	☐ NO	_____
Heart Trouble	☐ YES	☐ NO	_____
Kidney Disease	☐ YES	☐ NO	_____
Stomach Trouble	☐ YES	☐ NO	_____
Diabetes	☐ YES	☐ NO	_____
Diarrhea or Constipation	☐ YES	☐ NO	_____
Incontinent	☐ YES	☐ NO	_____

Fainting Spells	☐ YES	☐ NO	_____
Menstrual Problems	☐ YES	☐ NO	_____
Muscle Problems	☐ YES	☐ NO	_____
Neurological Problems	☐ YES	☐ NO	_____
Emotional Problems	☐ YES	☐ NO	_____
Psychological Problems	☐ YES	☐ NO	_____
Psychiatric Problems	☐ YES	☐ NO	_____

IMPORTANT

If there is any further information you feel should be provided which is a factor and could influence the care, health, and well-being of this individual at UP, please explain:

_____

_____

_____

_____

_____

_____

_____

_____

The information in the above medical history is correct to the best of my knowledge.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Applicant (if appropriate) Date

UP strives to provide financial assistance to those in need who qualify.

Unending Possabilities Monthly Tuition (Four day program) **$600**

Will you be requesting Financial Assistance? Yes or No

Please note that the application must be completed <u>in full</u> before it can be reviewed.

Please read and sign:

I affirm the preceding information is a complete and true statement of all the facts and circumstances pertinent to this client's application for enrollment in Unending Possabilities.

We, the undersigned, do give our permission for Unending Possabilities to contact any and all of the references, programs, schools, and professionals listed on this application.

I also authorize anyone who has any information on this client to release said information they hold on him/her to Unending Possabilities.

Copies of this release may be used to obtain information from anyone listed on application for acceptance into Unending Possabilities.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Applicant (If appropriate) Date

PHOTOGRAPH/ IMAGE CONSENT

UP would like your permission to use images/photos that may include your applicant.

I hereby grant permission to UP to photograph and video me, and otherwise capture my image, and to make recordings of my voice. I further grant to UP the right to reproduce, use, exhibit, display, broadcast and distribute these images and recordings in any media now known or later developed for promoting, publicizing or explaining UP and its activities and for administrative, educational or research purposes. Photographs, video images and voice recordings are the property of the UP.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Applicant (If appropriate) Date

MEDICAL TREATMENT CONSENT

During Volunteer Days at Unending Possabilities, we need the following consent signed in case a medical emergency should arise and your Applicant need immediate medical care or emergency transport to a hospital.

The UP staff has my consent to obtain medical assistance and treatment for both routine and emergency care for:

_____

Name of Applicant (please print)

Treatment includes but is not limited to the following:

- Ambulance transport to Hospital or Emergency Care facility
- Hospital admission for in-patient care
- Administering of prescribed medications
- X-Rays
- Lab Work

This authorization is valid throughout application process and Volunteer Days worked in Unending Possabilities.

Signature: _____ Date: _____

Relationship: _____