

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 to UP must be age 20 or older.**

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 Competitive Employment

Sheltered Workshop State School

Group / Family Care Home Private School

Independent Living Situation 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?

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

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

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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 surgery? ⁬ 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 (3 day program) **$500**

**Will you be requesting Financial Assistance? Yes or No**

***Please note that the application must be completed in full before it can be reviewed.***

Please read and sign:

I affirm that 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

UNENDING POSSABILITIES CONSIDERS ALL APPLICANTS REGARDLESS OF SEX, RACE, RELIGION, OR ETHNIC ORIGIN.

**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: