217 Coxe Ave
Asheville, NC 28801
(828) 505-8428
info@openheartsartcenter.org

ADMISSION APPLICATION/ASSESSMENT

Consent For Assessment:____
Signature of legally responsible person Date

Applicant Name: ____ DOB:_______________________

Address:____

Guardian's name: _______________________ Guardian's phone number: _______________________________

Guardian's address: ____

Medicaid ID#: _______________________ Record#:_________________________________

Email address:____

(_____)___________________ (_____)___________________ (_____)___________________
Home Phone Number Cell Phone Number Work Phone Number

Resides with (check all that apply): ☐ Mother ☐ Father ☐ Siblings ☐ Guardian ☐ Other____________

Referral Source: ☐ MCO ☐ Care Coordinator ☐ Family ☐ Friend ☐ Other (specify)_________________

List All Diagnoses/Disabilities (USE ADDITIONAL SHEET, IF NEEDED):

____

____

Service(s) Requested: ☐ Day Supports ☐ Private Pay ☐ Community Networking ☐ Supported Employment

Present Day Services: ____Status: _____________________

Residential Placement: ____ Status:______________________

Will there be a need for specific staff training requirements other than CPR, First Aid, Blood Borne Pathogens, NCI A?

____

How will applicant be transported? ____

Case Responsible Agency, Care Coordinator, Phone #:____

Is the Care Coordinator aware of your application to Open Hearts Art Center? ☐Yes ☐No

Information observed during the tour/sample class is confidential.

Citizen: ☐ Yes ☐ No **Gender:** ☐ Male ☐ Female

Racial or Ethnic Group: ☐ American Indian/Alaskan ☐ Asian/Pacific Islander ☐ White/Caucasian ☐ Hispanic/Latino ☐ Black/African American ☐ Other ______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Religion/Culture: ___________________________ **Affiliations not mentioned**: _________________

Work Status: ☐Employed ☐Non-employed

Sexual Orientation: ☐Heterosexual ☐ Lesbian/Gay/Bisexual ☐Not specified

Roles: ☐Parent ☐Non-parent ☐Caregiver ☐Veteran

Please share anything about your specific culture that would help Open Hearts better meet your cultural needs? ____
____
____
____

Please state any needs that have not been addressed: ____
____
____

Primary Care Physician

Name of Physician: ____

Address:_______________________________________ ______________Phone:______________________________

In the event of an emergency, Open Hearts Art Center will seek emergency care according to information provided below unless otherwise directed. Who should be contacted I an emergency, if parent/guardian cannot be reached? (Please try to list one relative as one of the two contacts.)

Name: ____Relationship to participant_________________________

Address: ____

Home Phone______________________________Mobile______________________Work________________________

Please list the name of the hospital that parent/guardian would prefer the participant be taken to in the event of an emergency and is unable to be reached:

Hospital Name:____Phone:_______________________________

I. DEVELOPMENTAL INFORMATION (PLEASE CHECK THE BOX NEXT TO THE PHRASES WICH BEST DESCRIBE APPLICANT)

LEVEL

☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Unknown

A. AMBULATION AIDS

☐ Wheelchair ☐ Crutches ☐ Walker ☐ Braces ☐ Stroller ☐ None

B. VISUAL DIFFICULTY

☐ None ☐ Slight ☐ Great ☐ Legally Blind ☐ No Vision
☐ Undetermined ☐ Wears Glasses

C. HEARING

☐ Normal ☐ Mild Loss ☐ Moderate Loss ☐ Severe Loss
☐ Undetermined ☐ Wears Hearing Aid

D. EXPRESSIVE LANGUAGE

☐ Uses Verbal Language Clearly: ☐ Sentences ☐ Phrases ☐ Single Words
☐ Uses Formal Sign Language ☐ Manual ☐ Or Symbol Communication
☐ Uses informal communicative gestures ☐ Vocalizes to express needs ☐ Non-Verbal

E. RECEPTIVE LANGUAGE

☐ Comprehends many words ☐ Comprehends some words
☐ Attends to gestures and auditory cues
☐ Does not respond to gestural or auditory stimuli.

F. TOILETING SKILLS

☐ Never has accidents ☐ Frequently has accidents during day
☐ Occasionally has accidents during the day
☐ Uses toilet with cues and assistance ☐ Uses toilet with cues daily
☐ Is not toilet trained at all ☐ Uses Disposables

Frequency of urination: Frequency of bowel movements:

How does client indicate toileting needs?

____

Describe any special problems with toilet habits:

____

What is done to resolve these?

____

G. MEALTIME SKILLS

☐ Uses utensils, neatly ☐ Uses utensils, spilling ☐ Uses spoon, neatly
☐ Uses spoon, spilling ☐ Feeds self with fingers ☐ Feeds self with adapted equipment
☐ Drinks from cup, unassisted ☐ Drinks from cup, assisted
☐ Sucking, chewing, swallowing - developed ☐ Sucking, chewing, swallowing - delayed
☐ Eats at table ☐ Eats in chair with tray

Describe any feeding or diet problems or concerns :______________________________

H. SOCIALIZATION SKILLS

☐ Participates in groups ☐ Initiates interactions with others
☐ Responds to others

Other: ______________________________

Likes: ______________________________

Dislikes: ______________________________

I. BEHAVIORAL CONCERNS (Please Specify)

☐ Verbal Aggression: ______________________________
☐ Physical Aggression: ______________________________
☐ Sexual Issues ______________________________
☐ Self-Injury: ______________________________
☐ Property Damage ______________________________
☐ Tantrums: When? ______________________________
☐ Non-Compliance: ______________________________
☐ Wandering ☐ Crying, Whining ☐ Mouthing objects ☐ PICA

List situations that trigger aggression or other tantrum:

____

☐ Behavior Plan If yes, who generated/monitors the behavior plan? ____

I. MEDICAL INFORMATION

A. EXISTING CONDITIONS/DISABILITIES & HEATH HISTORY

☐ Allergies/Food Sensitivities Explain___________________________________ ☐ None

Current or previous life-threating illness_________________________

Admitting Diagnosis: ______________________________________

Hospitalizations: ______________________________________Code # ____________

B. SEIZURE FREQUENCY (if applicant has seizure disorder)

☐ None ☐ Unknown ☐ Less Than 1 per year ☐ 3-6 seizures per year
☐ Monthly seizures ☐ Weekly seizures ☐ Daily Seizures ☐ More than 1 seizure per day

Seizure Type: ______________________________

C. CURRENT MEDICATION PROFILE:

How Taken: ☐ Pill ☐ Liquid ☐ Crushed Other: ☐ ______________________

Will you require Medication at Open Hearts? ☐Yes ☐ No

If yes how are they to be administered?____

II. OTHER INFORMATION/DESIRED OUTCOMES

Desired Outcomes: ______________________________
____
____
____

Will adaptive/protective equipment (wheel chair with seatbelt, helmet, glasses, leg braces, etc) need to be used?

☐ Yes ☐ No If yes, what type of equipment will be needed?____

____

____

CONFIDENTIALITY NOTICE: This agency contains confidential information and is intended only for use by authorized employees of Open Hearts Art Center. Disclosing, copying, distribution or taking any action in reliance on the content of the information you may receive, view and/or hear while vising our facility is strictly prohibited. By signing below, you acknowledge that you have read, understand, and agree not to disclose any confidential information you may encounter while visiting Open Hearts Art Center (individuals touring/attending sample classes will be asked to sign confidentiality statements upon entrance into the facility).

____ _______________

Signature of legally responsible person Date

END OF REQUIRED INFORMATION

The following sections will be completed by Open Hearts Staff:

Open Hearts Art Centers strategies to serve clients' needs:

____
____
____

*Referral and recommendation source:*____

Disposition of applicant:

____
____
____
____
____
____
____
____