Bittersweet Farms
Preliminary Application for Services/Waiting List

The following information requested will be used for the purpose of gaining valuable details pertaining to the individual's development in order to assess their need for present as well as future services. To allow us to most accurately assess this individual, please be as complete as possible.

Today's date: _____

Basic Information:

Name of individual:_____Date of birth:_____

Current address of individual:_____

City:_____ State:_____ Zip:_____ County:_____

Telephone:_____ Social Security #:_____

Medicare #:_____ Medicaid #:_____

Place of birth:_____Is the individual a US citizen: Y N

Age:_____ Gender:_____ Height:_____ Weight:_____

Hair color:_____ Eye color:_____

Identifying marks:_____

Religious affiliation, if any:_____

Guardian Information: If the person is their own guardian, please indicate that on the first line and skip this section.

Legal guardian name (probate court appointed)_____

Address:_____

Telephone (Home):_____(Work)_____

E-mail address: _____

Service and Support Information: please fill out this section if the individual has a caseworker or SSA at their County Board

County Caseworker name:_____

Email:_____

County:_____ Telephone:_____

Funding source for support services (circle one) Waiver Medicaid Private Pay Other:_____

Family History:

Guardian's name:_____

Address:_____

Telephone:_____ E-mail:_____

Relationship to applicant: _____

Employer:_____ Telephone:_____

Other Parent/Guardian:_____

Address:_____

Telephone:_____ E-mail:_____

Relationship to applicant: _____

Employer:_____ Telephone:_____

Natural parents' marital status:_____

How does individual relate to:

Mother:_____

Father:_____

Siblings:_____

_____

Emergency contact in addition to parents/guardian:

Name:_____

Relationship to individual:_____

Address:_____

Home phone:_____Work/Cell phone:_____

Medical History:

Name of primary physician:_____ Telephone:_____

Address:_____

Name of dentist:_____ Telephone:_____

Address:_____

Name of specialist:_____ Telephone:_____

Address:_____

Current Medications:

Name of medication	Date Started	Dosage	Purpose

Allergies (food, medication, animals, seasonal, other)

Allergy	Reaction

Preferred OTC medications:
Pain relief: (please circle one or more) Tylenol Advil Aleve Aspirin Other
Sinus/Cold relief_____
Other OTC medication_____

Current diagnoses:
_____

Note: Failure to disclose all diagnosis that could change the service picture may lead to a 30 day notice to discontinue services. Please initial you have read and understand. _____

Date Autism Spectrum Disorder officially diagnosed: _____

Please list dates and reasons for any surgeries:
_____
_____
_____

Date of last physical:_____Age where developmental delay first noticed:_____
Adaptive equipment:_____
Physical limitations:_____
Special diet instructions: _____
_____

Present health of the individual: _____

Any current medical concerns: _____
_____

Personal History:

Education:
Name and address of school:_____
_____Dates attended:_____

Name and address of school:_____
_____Dates attended:_____

Employment: (please include sheltered workshops/activity centers)
Employer name and address:_____
_____Dates employed:_____

Employer name and address:_____
_____Dates employed:_____

Any previous residential placement and reason for transfer:
_____

Has the individual ever plead guilty or " no contest " to a crime or been convicted of a crime (felony or misdemeanor ?) and or have criminal charges pending? _____Yes_____No

Sources of additional information (any professional, specialist or agency not previously listed who may be able to provide information about the individual):

Name Phone Contact person Type of services provided

_____

_____

_____

Please mark the service(s) the individual would like to receive (either currently or long term):

- □ Adult Residential - ICF/DD – Whitehouse
- □ Adult Residential - Community Living Whitehouse (waiver funded)
- □ Adult Residential - HUD Housing/BRK Community Living Whitehouse (waiver funded)
- □ Adult Residential – Pemberville
- □ Adult Day Program/Habilitation/Vocational - Whitehouse
- □ Adult Day Program/Habilitation - Lima
- □ Adolescent Transition School (12 to 21 years of age) - Pemberville
- □ Summer Enrichment –Waiver not accepted (Adolescent Summer Camp for 13 to 22 years of age) – Whitehouse or Pemberville
- □ Respite services (only available once currently being served – 18 years or older)
- □ Social Recreation Program- Waiver not accepted (13 years and older) – Whitehouse or Lima

Date ready to begin services: _____

Funding Sources:

□ Medicaid:	□ Currently have	□Currently applying	□ Not as this time
□ Medicare:	□ Currently have	□Currently applying	□ Not as this time
□ Level 1 Waiver:	□ Currently have	□Currently applying	□ Not as this time
□ Individual Options (I.O.) Waiver:	□ Currently have	□Currently applying	□ Not as this time

- □ Private Pay
- □ Other _____

Are you interested in receiving our Bittersweet Spectrum newsletter? □ Yes □ No
If yes, please provide your email : _____

_____ _____
Signature of person completing form Date

_____
Relationship to applicant

Please return to: Waiting Lists Services c/o Tammy Bolley-Chambers 12660 Archbold-Whitehouse Rd. Whitehouse, OH 43571 -or- Fax # 1-419-875-5593
Send questions to: 419-875-6986, Ext. 1230 -or- admissions@bittersweetfarms.org