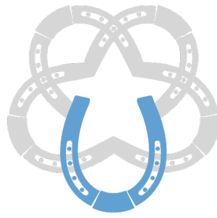


APPLICATION FOR SERVICES

Notice: By signature below, I/we are voluntarily requesting services from Blue Sky Therapeutic Riding and Respite and understand that consideration will be given to this Application for Services without regard to race, color, or national origin.

This Application for Services is being completed by: ___________________________________

Relationship to the applicant: ______________________________ Date: ________________

Parent, Individual, or Legally Responsible Person:

Printed Name: ________________________________ Signature: __________________________

Printed Name: _________________________________Signature: __________________________

IDENTIFYING INFORMATION

Individual's name: ____

Gender: _________ **Date of Birth:** _____________ **Referred by:** _____________________

Current address: ____

Primary phone: (____)________________ **Alternate phone:** (_____)___________________

Medicaid # _________________________ **Social security #** ____________________________

Medicare # __________________________ **Prescription Drug Plan:** _____________________

Any third party coverage: _______________________________

List all services this individual is currently receiving: _________________________________

____

List all previous services this individual has received (psychiatric care, rehabilitation services, etc.)

Service type/location	Length of service	Reason service was discontinued
__________________	_______________	_____________________________
__________________	_______________	_____________________________
__________________	_______________	_____________________________
__________________	_______________	_____________________________
__________________	_______________	_____________________________

LEGAL INFORMAION

Guardianship Status

- Own guardian
- Minor/custodian
- Limited guardian
- General guardian
- Power of attorney
- Guardian (s) of the person

Name of guardian (s): ____

Qualification date: _________________

Successor guardian preference, if known: ____

Special needs trust established

Yes No

Pre-need burial established

Yes No

Final Planning if known or established: ____

SOCIAL/FAMILY

Mother :

Name: DOB: Place of Birth:

Address: E-mail:

Primary Phone # (_______________________________)

Alternate Phone # (___________________________)

Occupation:

Social Security # :

Father:

Name: DOB: Place of Birth:

Address: E-mail:

Primary Phone # (_______________________________)

Alternate Phone # (_______________________________)

Occupation:

Social Security #

Siblings:

Name	Date of Birth	Contact Information
_________________________	_______________	______________________________
_________________________	_______________	______________________________
_________________________	_______________	______________________________
_________________________	_______________	______________________________
_________________________	_______________	______________________________

Other Significant Persons:

Name	Relationship	Contact Information
_________________________	_______________	______________________________
_________________________	_______________	______________________________
_________________________	_______________	______________________________

FAMILY MEDICAL HISTORY

Respiratory (e.g. Asthma, Allergies, Cystic Fibrosis, Tuberculosis, etc)

Yes ______________   Relationship to Individual _____________

No

Cardiovascular (e.g. Heart disease, Hypertension, etc)

Yes _______________ Relationship to Individual ______________

No

Gastro-Intestinal (e.g. Ulcers, Bowel difficulties, etc)

Yes _______________ Relationship to Individual ______________

No

Endocrine (e.g. Diabetes, Thyroid Disease, etc)

Yes _______________ Relationship to Individual ______________

No

Urinary (e.g. Kidney problems, etc)

Yes _______________ Relationship to Individual ______________

No

Neoplastic (e.g. Cancer, Tumors, etc)

Yes _______________ Relationship to Individual ______________

No

Neurological (e.g. Stroke, Migraines, Developmental Disability, Seizures, Alzheimer's, Cerebral Palsy, etc)

Yes _______________ Relationship to Individual ______________

No

Psychiatric (e.g. Depression, Bi-Polar, Schizophrenia, Anxiety, ADHD, Substance Abuse, etc)

Yes _______________ Relationship to Individual ______________

No

Additional Comments:

____

____

DEVELOPMENTAL INFORMATION

Pre-Natal. Please indicate any concerns which occurred during pregnancy:

____

____

Labor & Delivery

Pre-Mature ______________________ Caesarean Section Breech

Other information regarding labor & delivery: ___________________________________

____

Birth Weight: _____________________

DEVELOPMENTAL MILESTONES

As closely as you can recall, please write the age when he/she did the following:

Started solid foods: Fed self with utensils: Rolled over: Stood:

Crawled: Walked: Bladder: Trained Bowel: Trained Dressed:

When did you first notice learning or social difficulties in the individual? _______________

____

____

When did it seam serious enough to seek professional help? _________________________

Indicate whether or not he/she can do the following:

Sort by size Yes No

Sort by color Yes No

Sort by function Yes No

Correctly spell/write name Yes No

Count 10 or more objects Yes No

Tell time on the hour Yes No

Tell time on the half hour Yes No

Understand functional signs (exit, bathroom, etc) Yes No

Do simple addition & subtraction Yes No

Read/comprehend simple sentences Yes No

Read/comprehend newspaper or magazines Yes No

Understand meaning of "no" Yes No

Understand one-step directions Yes No

Understand multi-step directions Yes No

Ask a simple question Yes No

Relate experience when asked Yes No

Tell a story, joke, or plot Yes No

Describe realistic plans in detail Yes No

Identify currency Yes No

Make simple purchases Yes No

Make correct change Yes No

Use checking/savings account Yes No

Indicate the level of assistance he/she needs to do the following:

Feed Him/Herself:

None (can do on his/her own)

Minimal assistance such as verbal reminders or gesture prompts

Partial assistance – needs some hands-on guidance

Complete assistance – needs full support of others

Dress Him/Herself:

None (can do on his/her own)

Minimal assistance such as verbal reminders or gesture prompts

Partial assistance – needs some hands-on guidance

Complete assistance – needs full support of others

Participate in Household Chores:

None (can do on his/her own)

Minimal assistance such as verbal reminders or gesture prompts

Partial assistance – needs some hands-on guidance

Complete assistance – needs full support of others

Bathe/Shower/ Brush Teeth:

None (can do on his/her own)

Minimal assistance such as verbal reminders or gesture prompts

Partial assistance – needs some hands-on guidance

Complete assistance – needs full support of others

____

How does he/she get his/her message across to others? **Answer the following and provide specific examples for "yes" answers.**

Does he/she make requests for things that he/she wants/desires? No Yes

____

Does he/she make requests for things that he/she needs? No Yes

____

Is he/she able to reject or refuse things that are undesirable? No Yes

____

Is he/she able to gain the attention of others? No Yes

____

Is he/she able to make or provide comments? No Yes

____

Is he/she able to give information (observations about things which might not readily be known)? No Yes

____

Is he/she able to seek information from others? No Yes

____

Does he/she engage in any social routines? No Yes

____

Additional Comments:

____

____

How does he/she understand what is being communicated to him/her? Give examples

Understands what is said to him/her

____

Understands gestures

____

Understand signs

____

Understands and uses special system (e.g. pictures, word cards, objects, schedule board, etc) ____

Additional Comments: ____

____

Please indicate how often, if ever, the individual does the following behaviors:

	Never	Not this year	Less than once a month	About once a month	About once a week	Several times a week	Once or more a day
Has tantrum or emotional outburst							
Damages own or others' property							
Disrupts others' activities							
Bites him/herself							
Scratches pinches him/herself							
Hits him/herself							
Bangs his/her own head							
Bites others							
Scratches/pinches others							
Hits others							
Kicks others							
Runs or wanders away							
Steals							
Eats/mouths inedible items							
Displays sexually inappropriate behavior							

Additional Comments: ____

____

____

____

____

MEDICAL INFORMATION

Allergies: Please indicate any food, drug, or environmental allergies along with reaction(s)

Allergy _______________________________ Reaction ____________________________

Allergy _______________________________ Reaction ____________________________

Allergy ________________________________ Reaction _____________________________

Medical Hospitalizations & Surgeries:

Date __________________________________ For _________________________________

Date __________________________________ For _________________________________

Date __________________________________ For _________________________________

Psychiatric Hospitalizations/Crisis Stabilization:

Date __________________________________ For _________________________________

Date __________________________________ For _________________________________

Date __________________________________ For _________________________________

Current Medications. Please indicate all current prescriptions he/she takes

Medication Name	Instructions	Prescribed For
___________________________	____________________	_________________________
___________________________	____________________	_________________________
___________________________	____________________	_________________________
___________________________	____________________	_________________________
___________________________	____________________	_________________________
___________________________	____________________	_________________________
___________________________	____________________	_________________________
___________________________	____________________	_________________________

Continue to back side if needed

Previous Medications. Please list any previous medications he/she has taken: ___________

____

____

____

Which of the following best describes the level of support he/she need to take prescription medications:

Independent - the individual is totally responsible for his/her medication

Assistance - Staff/others keep medication; the individual participates with assistance

Total Support – Staff/others assumes total responsibility

Please indicate any health care issues he/she may be prone to develop (Headaches, seasonal allergies, constipation, ect.)

Condition	How is it usually treated?
______________________________	____
______________________________	____
______________________________	____

How does he/she indicate that he/she may not be feeling well?

____

____

Hearing:

Undetermined

Normal

Mild Loss (Difficulty hearing normal speech)

Moderate Loss (Difficulty hearing loud speech)

Severe Loss (Can only hear amplified speech)

Profound Loss

Vision:

Undetermined

Normal

Moderate Impairment (trouble seeing distances, curbs, etc.)

Severe Impairment (Cannot see faces, line on which to write or mark)

Light Perception (Sees only light and/or shadows)

Blind

Mobility:

Walks independently

Walks independently, but with difficulty

Walks independently with corrective device

Walks only with assistance from another person

Does not walk

Additional comments regarding hearing, vision, or mobility:

____

____

Sleep Habits:

He/she typically sleeps: All night 3-5 hours a night Less than 3 hours a night

He/she uses: A standard bed An adapted bed Bed rails

He/she prefers: A room alone A room with others

Additional comments regarding sleep habits: ____

____

Is he/she on a special diet? Yes No ____

Does he/she require staff that are trained in special health care procedures? Yes No

____

Medical Concerns

Respiratory (e.g. asthma, allergies, Cystic Fibrosis, Tuberculosis, etc)

No Yes ____

Cardiovascular (e.g. Heart Disease, etc)

No Yes ____

Endocrine (e.g. Diabetes, Thyroid Disease, etc)

No Yes ____

Gastro-Intestinal (e.g. Ulcers, Bowel difficulties, etc)

No Yes ____

Urinary (e.g. Kidney Problems, etc)

No Yes ____

Neoplastic (e.g. Cancer, Tumors, etc)

No Yes ____

Neurological (e.g. Stroke, Migraines, Developments Disability, Cerebral Palsy,etc)

No Yes ____

Seizures No Yes-Describe typical seizures: ______________________________________

____

Frequency of Seizures: None during the past year Less than once a month

Once a month About once a week Several times a week Once a day or more

Psychiatric (e.g. Depression, Bi-Polar, Schizophrenia, Anxiety Substance Abuse, etc.)

No Yes ____

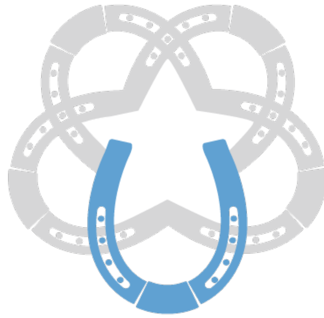
Current Primary Physician: ____

Practice Name: ____

Address: ____

Primary Phone # (______________________________)

Fax # (____)



BLUE SKY

Therapeutic Riding & Respite

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****PLEASE RETURN FORMS TO AMY@BLUESKYTEXAS.ORG**