



Brookwood in Georgetown  
905 N. Church St.  
Georgetown, TX 78626  
512-688-5004  
[www.brookwoodingeorgetown.org](http://www.brookwoodingeorgetown.org)

## Application for Admissions

Thank you for your interest in Brookwood in Georgetown. Please complete and return the following items:

- Application
- Medical History
- Release of Information
- Application fee of \$100 (nonrefundable) Day Program
- 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 Brookwood in Georgetown 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 512-688-5004.

All applicants to BiG must be age 20 or older.

## Brookwood in Georgetown Application for Admissions

Please complete the application in full and return with the appropriate application fee, a recent individual photograph, and a family photograph. Application will not be reviewed unless photos and fee are attached.

<b>I AM APPLYING FOR:</b>			
<input type="checkbox"/> Residential/Work Program		<input type="checkbox"/> Day Work Program (Please specify which campus)	
		<input type="checkbox"/> Main Campus <input type="checkbox"/> LIGHT Texas <input type="checkbox"/> ATX Georgetown                      Georgetown                      Austin	
<b>Requested placement date:</b>			
<b>APPLICANT INFORMATION</b>			
Name:		Birthdate:	
Preferred Name:	Phone:	SSN:	
Current Address:			
City:		State:	Zip:
Height:	Weight:	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>FAMILY INFORMATION/EMERGENCY CONTACTS</b>			
Mother's Name:			
Home Address:			
City:	State:	Zip:	
Preferred Email:			
Occupation/Company Name:			
Home Phone:	Cell:	Work:	
Father's Name:			
Home Address:			
City:	State:	Zip:	
Preferred Email:			
Occupation/Company Name:			
Home Phone:	Cell:	Work:	

Legal Guardian Name:			Relationship:		
Home Address:					
City:			State:		Zip:
Preferred Email:					
Occupation/Company Name:					
Home Phone:		Cell:		Work:	
<b>EMERGENCY INFORMATION/MEDICAL INSURANCE COVERAGE</b>					
Who would you like to be the first person contacted in the event of an emergency?					
Additional Emergency Contact (in addition to parent/guardian):					
Home Phone:		Cell:		Work:	
In the event of a transfer (if given an option) is there a hospital preference? If so, which hospital?					
Insurance Company:		Policy Number:		Group Number:	
Insurance Company Address:					
<b>FAMILY INFORMATION</b>					
Sibling Names				Ages	
<b>TOUR</b>					
Have you been on a tour of Brookwood or BiG? <input type="checkbox"/> Yes Location: _____ Date: _____ <input type="checkbox"/> No					

**SCHOOLS/PROGRAMS ATTENDED**

Check all situations in which the applicant has participated.

<input type="checkbox"/> Day School	<input type="checkbox"/> Competitive Employment
<input type="checkbox"/> Sheltered Workshop	<input type="checkbox"/> State School
<input type="checkbox"/> Group/Family Care Home	<input type="checkbox"/> Private School
<input type="checkbox"/> Independent Living Situation	<input type="checkbox"/> Special Olympics
<input type="checkbox"/> Church/Spiritual Involvement	<input type="checkbox"/> Other (please explain)

**PLEASE COMPLETE THE FOLLOWING INFORMATION ON EACH PROGRAM**

Name:	Dates:
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Address:

City:	State:	Zip:
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Type of Situation (refer to list at top of page):

Reason for Leaving:

Person to Contact for More Information:

Name:	Dates:
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Address:

City:	State:	Zip:
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Type of Situation (refer to list at top of page):

Reason for Leaving:

Person to Contact for More Information:

Name:	Dates:
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Address:

City:	State:	Zip:
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Type of Situation (refer to list at top of page):

Reason for Leaving:

Person to Contact for More Information:

**SOCIAL SKILLS EVALUATION**

**EVALUATIONS & ASSESSMENTS**

Has the applicant had any of the following? If yes, give name of the person or agency. Include copies of reports from this person/agency.

Psychological Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	Person/Agency
Psychological Counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	Person/Agency
Psychiatric Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	Person/Agency
Psychiatric Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	Person/Agency
Speech/Language Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	Person/Agency
Medical Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	Person/Agency
Occupational Therapy/Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	Person/Agency

**QUESTIONS ABOUT THE APPLICANT**

Please describe applicant's general health, including special medical problems, diagnosis and/or disabilities:

Please describe applicant's communication abilities:

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

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

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

Please describe the applicant's daily routines and leisure (free time) activities:
What do you see to be the applicant's functional disabilities?
What do you think applicant feels are his/her disabilities?
What are the applicant's specific aptitudes, interests, and/or strengths?
Has the applicant ever been involved with any of the following? Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No      Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No Criminal Activity <input type="checkbox"/> Yes <input type="checkbox"/> No      Sexual Activity <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Please describe activity areas and/or situations that the applicant strongly dislikes:
How does the applicant respond to situations they don't like or that upsets them?
What techniques are used to de-escalate behaviors?
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?

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

Please describe your goals and expectations for the applicant and what you hope Brookwood in Georgetown can accomplish:

Does the applicant require constant at-home supervision?  Yes  No  
 Can the applicant be left at home to function independently?  Yes  No If yes, for what period of time? \_\_\_\_\_  
 What type of supervision does the applicant require in the community?  
  
 What type of supervision does the applicant require in parking lots?

**PLEASE CHECK WHICH OF THE FOLLOWING APPLIES TO THE APPLICANT:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> likes people</li> <li><input type="checkbox"/> gets along well with friends</li> <li><input type="checkbox"/> follows directions willingly</li> <li><input type="checkbox"/> shows concern</li> <li><input type="checkbox"/> prefers alone time</li> <li><input type="checkbox"/> respects rights &amp; property of others</li> <li><input type="checkbox"/> gets angry easily</li> <li><input type="checkbox"/> tends to be shy initially</li> <li><input type="checkbox"/> sensitive to light</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> sensitive to touch</li> <li><input type="checkbox"/> sensitive to sound</li> <li><input type="checkbox"/> can get easily agitated/irritable</li> <li><input type="checkbox"/> gets anxious</li> <li><input type="checkbox"/> has self-stemming behaviors</li> <li><input type="checkbox"/> perseverates</li> <li><input type="checkbox"/> can introduce self</li> <li><input type="checkbox"/> forms close relationships</li> <li><input type="checkbox"/> is generally happy</li> <li><input type="checkbox"/> other: _____</li> </ul> |
|--|---|

**WHICH OF THE FOLLOWING APPLY TO THE APPLICANT'S SPEECH/LANGUAGE AND COMMUNICATION SKILLS?**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> speaks spontaneously</li> <li><input type="checkbox"/> can make wants and needs known</li> <li><input type="checkbox"/> uses complete sentences</li> <li><input type="checkbox"/> has small vocabulary</li> <li><input type="checkbox"/> uses sign language</li> <li><input type="checkbox"/> understands lengthy dialogue</li> <li><input type="checkbox"/> makes little or no effort to communicate verbally or with gestures</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> understands short, direct commands</li> <li><input type="checkbox"/> communicates by writing</li> <li><input type="checkbox"/> comprehends written statements</li> <li><input type="checkbox"/> uses gestures effectively</li> <li><input type="checkbox"/> uses sentences effectively</li> <li><input type="checkbox"/> uses idiosyncratic gestures</li> <li><input type="checkbox"/> uses a communication device- please describe:<br/>_____</li> </ul> |
|--|---|

Describe the applicant's speech and language effectiveness:

SELF-HELP SKILLS			
Will an attendant accompany the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what is their primary role?			
MEALS		MOBILITY	
<input type="checkbox"/> no assistance needed <input type="checkbox"/> total assistance needed <input type="checkbox"/> some assistance needed <input type="checkbox"/> needs a straw for liquid <input type="checkbox"/> food needs to be cut/chopped <input type="checkbox"/> ability to prepare meals <input type="checkbox"/> able to use microwave independently Special instructions:		<input type="checkbox"/> walker <input type="checkbox"/> braces <input type="checkbox"/> crutches <input type="checkbox"/> manual wheelchair <input type="checkbox"/> electric wheelchair <input type="checkbox"/> not able to stand for prolonged periods of time <input type="checkbox"/> unsteady gate <input type="checkbox"/> has physical limitations that limit participation in activities Special instructions:	
SHOWERS		DRESSING	
<input type="checkbox"/> no assistance needed <input type="checkbox"/> total assistance needed <input type="checkbox"/> some assistance needed <input type="checkbox"/> helping shampooing hair only Special instructions:		<input type="checkbox"/> no assistance needed <input type="checkbox"/> total assistance needed <input type="checkbox"/> some assistance needed <input type="checkbox"/> needs help with buttons/zippers Special instructions:	
TOILETING			
<input type="checkbox"/> no assistance needed <input type="checkbox"/> help transferring <input type="checkbox"/> help cleaning up <input type="checkbox"/> wets bed <input type="checkbox"/> diapers/depends <input type="checkbox"/> assistance needed only after a bowel movement		<b>Bowel Control</b> <input type="checkbox"/> full control <input type="checkbox"/> limited control <input type="checkbox"/> no control <b>Bladder Control</b> <input type="checkbox"/> full control <input type="checkbox"/> limited control <input type="checkbox"/> no control Special instructions:	
OTHER SELF CARE			
<b>washing hands</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>washing face</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>brushing teeth</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>cleaning ears</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>combing hair</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>trimming fingernails</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>trimming toenails</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>using deodorant</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>shaving</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
<b>managing menstrual period (if applicable)</b>	<input type="checkbox"/> needs no help	<input type="checkbox"/> needs some help	<input type="checkbox"/> needs total help
Additional comments:			



MEDICAL HISTORY				
DIAGNOSIS				
Primary Diagnosis:		Secondary Diagnosis:		
Any other medical diagnosis:				
PHYSICIANS & DENTIST				
Name of applicant's primary physician:				
Address:		Phone:		
Date of last physical exam:				
Name of applicant's dentist:				
Address:		Phone:		
Date of last dental exam:				
List names of any other specialists who have treated or are treating the applicant:				
MEDICATIONS				
Is the applicant on any regular medications or supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please list below: (please use an additional sheet if necessary)				
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason for Medication:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason for Medication:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason for Medication:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason for Medication:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason for Medication:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason for Medication:

**ALLERGIES & RESTRICTIONS**

Is the applicant allergic to any medications?  Yes  No  
 If yes, please list:

Does the applicant have any other allergies or sensitivities: foods, pollens, insect bites, etc.?  Yes  No  
 If yes, describe what allergies/sensitivities, reactions, and what treatment is usually necessary.

Does the applicant have any dietary restrictions?  Yes  No  
 If yes, please list:

Does the applicant use an Epi Pen?  Yes  No If yes, one must be supplied by the participant  
 If on any medication/injection for allergies, please give name of medication/injection, dosage, and frequency:

**FAMILY HISTORY**

Since some conditions can be hereditary, or run in families, please provide the following information. If any member of the applicant’s family has had any of the following conditions or problems, please indicate and identity their relationship to the applicant.

<b>Hypertension</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:	<b>Stroke</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:
<b>Heart Attack</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:	<b>Kidney Disease</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:
<b>Diabetes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:	<b>Gout</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:
<b>Cancer</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:	<b>Arthritis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:
<b>Migraines</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:	<b>Glaucoma</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:
<b>Epilepsy</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:	<b>Other</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship:

**HISTORY OF ILLNESS, HOSPITALIZATION, & SURGERY**

Has the applicant had more than a brief illness during the past three years?  Yes  No  
 If yes, when?  
 Please describe:  
  
 Name and address of attending physician:

Has applicant ever been hospitalized?  Yes  No  
 If yes, when?  
 Describe:  
 Please list hospital and address:

Has applicant had any surgery?  Yes  No  
 If yes, when?  
 Describe:  
 Please list hospital and address:

**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. List preferred treatment if applicable. If extra space is needed, use separate piece of paper and attach.

<b>Headaches</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Eyes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Ears</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Hearing</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Chest Infections</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Asthma</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Epilepsy/Seizures</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Tuberculosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Heart Trouble</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Kidney Disease</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Stomach Trouble</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Diabetes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Diarrhea or Constipation</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Fainting Spells</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Menstrual Problems</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Muscle Problems</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Neurological Problems</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Emotional Problems</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Psychological Problems</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Psychiatric Problems</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>HIV</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Hepatitis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Other</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list all childhood diseases (mumps, measles, chickenpox, etc.)

**IMMUNIZATION RECORD**

Please check YES if applicant has been given a vaccination from each of the following diseases. If yes, please write down date of last vaccination. If no, please leave date blank.

<b>Measles</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
<b>Mumps</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
<b>Rubella</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
<b>Tetanus &amp; Diphtheria</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
<b>Tetanus Booster</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
<b>Polio (indicate OPV or IPV)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
<b>Tuberculosis</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
<b>Hepatitis B</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:

**AIDS & DEVICES**

Does the applicant use any of the following:

- Glasses
- Hearing Aids
- Prosthetics
- Other: \_\_\_\_\_

**FAMILY PLANNING**

Do you or someone else have guardianship of the applicant?    Yes    No

Are you signed up or on any federal waiver programs?    Yes    No

If yes, which one(s)?

**ADDITIONAL INFORMATION**

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 Brookwood in Georgetown, please explain:

**FINANCIAL INFORMATION**

Listed below are the fees associated with the Residential and Day Programs. Brookwood in Georgetown strives to provide financial assistance to those in need and to those who qualify.

Day Program \$880/month	Residential & Work Program \$3,000/month + \$880/month
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Have you had a financial assessment done by a trained special needs financial planner?  Yes  No

Name of Financial Professional: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Will you be requesting financial assistance?**  Yes  No

**REFERENCES**

Please list three (3) individuals (different from those listed on page 3) who have worked with or known the applicant closely:

Name:		Phone:		
Address:		City:	State:	Zip:
Email:				

Name:		Phone:		
Address:		City:	State:	Zip:
Email:				

Name:		Phone:		
Address:		City:	State:	Zip:
Email:				

**APPLICATION SIGNATURES**

I affirm that the preceding information is a complete and true statement of all the facts and circumstances relative to this participant’s application for enrollment at Brookwood in Georgetown’s residential or day program.  
 We, the undersigned, do give our permission for Brookwood in Georgetown 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 Brookwood in Georgetown.  
 Copies of this release may be used to obtain information from anyone listed on application for acceptance into Brookwood in Georgetown.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant (if appropriate): \_\_\_\_\_ Date: \_\_\_\_\_

If application was filled out by someone other than parent/guardian, please sign below:  
 Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**PHOTOGRAPH/IMAGE CONSENT**

BiG would like your permission to use images/photos that may include your applicant.  
 I hereby grant permission to BiG to photograph and video me, and otherwise capture my image, and to make recordings of my voice. I further grant to BiG 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 BiG and its activities and for administrative, educational or research purposes. Photographs, video images, and voice recordings are the property of BiG.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant (If appropriate): \_\_\_\_\_ Date: \_\_\_\_\_

BROOKWOOD IN GEORGETOWN CONSIDERS ALL APPLICANTS REGARDLESS OF SEX, RACE, RELIGION, OR ETHNIC ORIGIN.

**MEDICAL TREATMENT CONSENT**

During volunteer days at Brookwood in Georgetown, 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 Brookwood in Georgetown staff has my consent to obtain medical assistance and treatment for both routine and emergency care for: (name of applicant) \_\_\_\_\_

- 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 Brookwood in Georgetown.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

