Brookwood in Georgetown
905 N. Church St.
Georgetown, TX 78626
512-688-5004
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.

I AM APPLYING FOR:			
□ Residential	□ Work Program	□ Day Work Program (Please specify which campus) □ Main Campus Georgetown □ LIGHT Texas Georgetown □ ATX Austin	
Requested placement date:			
APPLICANT INFORMATION			
Name:			Birthdate:
Preferred Name:	Phone:		SSN:
Current Address:			
City:		State:	Zip:
Height:	Weight:	Gender: □ Male □ Female	
FAMILY INFORMATION/EMERGENCY CONTACTS			
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:

EMERGENCY INFORMATION/MEDICAL INSURANCE COVERAGE

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:		

FAMILY INFORMATION

Sibling Names	Ages

TOUR

Have you been on a tour of Brookwood or BiG? □ Yes Location: _____ Date: _____ □ No

SCHOOLS/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	□ Special Olympics
□ Church/Spiritual Involvement	□ Other (please explain)

PLEASE COMPLETE THE FOLLOWING INFORMATION ON EACH PROGRAM

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:		

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:		

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:		

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	□ Yes □ No	Dates:	Person/Agency
Psychological Counseling	□ Yes □ No	Dates:	Person/Agency
Psychiatric Evaluation	□ Yes □ No	Dates:	Person/Agency
Psychiatric Hospitalization	□ Yes □ No	Dates:	Person/Agency
Speech/Language Assessment	□ Yes □ No	Dates:	Person/Agency
Medical Evaluation	□ Yes □ No	Dates:	Person/Agency
Occupational Therapy/Physical Therapy	□ Yes □ 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	□ Yes	□ No	Drug Use	□ Yes	□ No
Criminal Activity	□ Yes	□ No	Sexual Activity	□ Yes	□ 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:

- □ likes people
- □ gets along well with friends
- □ follows directions willingly
- □ shows concern
- □ prefers alone time
- □ respects rights & property of others
- □ gets angry easily
- □ tends to be shy initially
- □ sensitive to light
- □ sensitive to touch
- □ sensitive to sound
- □ can get easily agitated/irritable
- □ gets anxious
- □ has self-stemming behaviors
- □ perseverates
- □ can introduce self
- □ forms close relationships
- □ is generally happy
- □ other: _____

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

- □ speaks spontaneously
- □ can make wants and needs known
- □ uses complete sentences
- □ has small vocabulary
- □ uses sign language
- □ understands lengthy dialogue
- □ makes little or no effort to communicate verbally or with gestures
- □ understands short, direct commands
- □ communicates by writing
- □ comprehends written statements
- □ uses gestures effectively
- □ uses sentences effectively
- □ uses idiosyncratic gestures
- □ uses a communication device- please describe: _____

Describe the applicant's speech and language effectiveness:

SELF-HELP SKILLS

Will an attendant accompany the applicant? □ Yes □ No

If so, what is their primary role?

MEALS

□ no assistance needed
□ total assistance needed
□ some assistance needed
□ needs a straw for liquid
□ food needs to be cut/chopped
□ ability to prepare meals
□ able to use microwave independently

Special instructions:

MOBILITY

□ walker
□ braces
□ crutches
□ manual wheelchair
□ electric wheelchair
□ not able to stand for prolonged periods of time
□ unsteady gate
□ has physical limitations that limit participation in activities

Special instructions:

SHOWERS

□ no assistance needed
□ total assistance needed
□ some assistance needed
□ helping shampooing hair only

Special instructions:

DRESSING

□ no assistance needed
□ total assistance needed
□ some assistance needed
□ needs help with buttons/zippers

Special instructions:

TOILETING

□ no assistance needed
□ help transferring
□ help cleaning up
□ wets bed
□ diapers/depends
□ assistance needed only after a bowel movement

Bowel Control □ full control □ limited control □ no control

Bladder Control □ full control □ limited control □ no control

Special instructions:

OTHER SELF CARE

washing hands	□ needs no help	□ needs some help	□ needs total help
washing face	□ needs no help	□ needs some help	□ needs total help
brushing teeth	□ needs no help	□ needs some help	□ needs total help
cleaning ears	□ needs no help	□ needs some help	□ needs total help
combing hair	□ needs no help	□ needs some help	□ needs total help
trimming fingernails	□ needs no help	□ needs some help	□ needs total help
trimming toenails	□ needs no help	□ needs some help	□ needs total help
using deodorant	□ needs no help	□ needs some help	□ needs total help
shaving	□ needs no help	□ needs some help	□ needs total help
managing menstrual period (if applicable)	□ needs no help	□ needs some help	□ 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? □ Yes □ 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:
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.

Hypertension	□ Yes □ No	Relationship:	**Stroke**	□ Yes □ No	Relationship:
Heart Attack	□ Yes □ No	Relationship:	**Kidney Disease**	□ Yes □ No	Relationship:
Diabetes	□ Yes □ No	Relationship:	**Gout**	□ Yes □ No	Relationship:
Cancer	□ Yes □ No	Relationship:	**Arthritis**	□ Yes □ No	Relationship:
Migraines	□ Yes □ No	Relationship:	**Glaucoma**	□ Yes □ No	Relationship:
Epilepsy	□ Yes □ No	Relationship:	**Other**	□ Yes □ 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.

Headaches	□ Yes □ No	
Eyes	□ Yes □ No	
Ears	□ Yes □ No	
Hearing	□ Yes □ No	
Scoliosis	□ 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	
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	
HIV	□ Yes □ No	
Hepatitis	□ Yes □ No	
Other	□ Yes □ 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.

Measles	□ Yes □ No	Date:
Mumps	□ Yes □ No	Date:
Rubella	□ Yes □ No	Date:
Tetanus & Diphtheria	□ Yes □ No	Date:
Tetanus Booster	□ Yes □ No	Date:
Polio (indicate OPV or IPV)	□ Yes □ No	Date:
Tuberculosis	□ Yes □ No	Date:
Hepatitis B	□ Yes □ 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	Residential & Work Program
$925/month	$3,000/month + $925/month

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: _____