Amazing Hands Health Services, LLC
9229 Matthew Dr
Manassas Park VA 20111
Tel#: 240-423-4691/240-425-2477
Fax: 703-563-9168

APPLICATION FOR ADMISSION

Please complete the application in full. If you are submitting an attachment, please indicate the attachment name and page number where information to the questions below can be found. If a question does not apply, please indicate N/A.

Level: _____ **Tier:** _____

SIS Information:

Date: _____

Personal/Health Information:

Name: _____Gender: _____Age:_____ Date of Birth: _____

Address: _____ Phone: _____
(Street) (City, State) (Zip)

Social Security #: _____ U.S. Citizen: _____

Legal Status (own guardian?):_____(If yes, has a capacity evaluation been completed?) Date: _____

Primary Language: _____

Parent Name: _____

Address: _____
(Street) (City, State) (Zip)

Home #:_____ Cell #:_____

Email Address: _____

Parent Name: _____

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Address: _____
(Street) (City, State) (Zip)

Home #:_____ Cell #: _____

Email Address:

_____

Sibling(s)/Significant Others:

Name: _____Relationship:_____

Address: Phone Number:

_____ _____
(Street) (City, State) (Zip)

Name: Relationship:

_____ _____

Address: _____ Phone Number: _____
(Street) (City, State) (Zip) Other

Contact Information:

Legal Guardian/Authorized Representative: _____

Relationship: _____

Address:

_____
(Street) (City, State) (Zip)

Home #:_____ Cell #:_____

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Power of Attorney (Healthcare, Financial): _____

Contact Information: _____

Advance Directive: (if applicable, please attach copy): _____

_____

Support Coordinator: _____**Phone Number:** _____

Referring CSB: _____**Fax Number:** _____

Address: _____ **Email:**_____
(Street/Suite) (City, State) (Zip)

Primary Care Physician: _____**Phone Number:** _____

Address: _____
(Street/Suite) (City, State) (Zip)

Current Diagnoses: _____

_____

_____

_____

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Please List the Dates Received for the Following Vaccinations: (*The following Vaccines are required for admissions into the program. please attach medical record as applicable)

TB/PPD TEST	Physical less than 30 days	Last dental

Consulting Physicians: (Cardiologist, Psychiatrist, Dermatologist, Neurologist, Dentist, Etc.)

Name	Specialty	Phone Number

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History of Applicant (including current status):

	Dates	Hospital/institution	Attending Physician	Type of Treatment
Previous Incarceration				
Mental Illness/ Psychiatric Treatment				
Alcohol or Drug Abuse				
Other Hospitalizations				

Medications: List all medications currently being taken (use additional pages as necessary).

Medication	Dosage	Frequency	Route	Reason	Prescribed by Doctor

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Present Conditions

Ambulatory	Impairing	special Precautions	Individual Has
☐ Independent	___Vision	___ Aggression	___ Dentures
☐ Wheelchair	___Hearing	___ Chokes easily	___ Eyeglasses
___Cane/Walker	___Speech	___ Hides Medication	___Hearing Aid
___Unsteady Gait	___Bowel/Bladder	___ Wanders	☐ Braces/Splint
		___ Elopes	☐ Other
		___ Other	

List and Purpose of Any Adaptive Equipment Not Otherwise Specified:

_____

_____

History of Illnesses/injuries: _____

_____

Date of Last Psychological Evaluation (please attach a copy): _____

Additional Comments Related to Medical/Healthcare: _____

_____

Drug Contraindications/Allergies: _____

Food Allergies: _____

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Self-Care Capabilities:

Self-Care Capability	Independent	Verbal Prompt	Physical Prompt	Total Assistance
Washing face and hands				
Bathing				
Hair Care				
Nail Care				
Shaving				
Brushing teeth and/or dentures				
Toileting				
Dressing/Undressing				
Feeding Abilities				
Use of Public Transportation				
Self-Medication				
Food Preparation				

Communication:

_____verbal ____Vocalizations ____Gestures _____Signs ☐communication Device(s): _____

Describe how individual interacts with others:

_____

_____

Describe the best way to interact with the individual: _____

_____

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Likes, Dislikes or Preferences of the Individual: _____

_____

_____

Is Individual Involved in Any Regular Community Activities: _____

_____

_____

Behavior Supports:

Does Individual currently/previously have a Behavior Supports Plan? Yes____No____

Name of Consultant: _____Company: _____

Phone Number: _____

Current Placement:

☐ Family Home ☐ Residential Group Home: _____ ☐ Other_____

Group/Other home contact info: _____

☐ Day Support:_____ ☐ School:_____ ☐ Other: _____

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Financial Information:

Waiver: ___ID Waiver
___DD Waiver
___Other Funding Source (please specify):_____

Income:	**Source**	**Amount**
	SSI_____	_____
	SSDI_____	_____
	Wages_____	_____
	Other_____	_____

Medical Insurance:

_____ Medicaid #_____

☐ Medicare #_____

☐ Other _____

Policy#: _____

Signature: _____ **Date:** _____

Title: _____

For Office Use:
Application Received: _____**Application** _____**Accepted** _____**Rejected** _____**Waiting List**

Admission Date: