Melvin J. & Claire Levine
Jewish Residential & Family Service
of Palm Beach County

Day Socialization Program
APPLICATION
Confidential and Privileged Information

Date: _____
E-mail Address:_____
(Please print)

1. APPLICANT'S IDENTIFYING INFORMATION:

Applicant's Name: _____

Address: _____

Phone: (_) _____ Citizenship:_____

Local Address (if different):_____

Local Phone: ( ) _____ Language Spoken:_____

Date of Birth:_____ Place of Birth: _____

Soc. Sec. # _____ Marital Status: _____

Sex: _____ Height:_____Weight: _____ Hair Color: _____ Eyes: _____

Ambulatory: Yes: _____ No: _____ Identifying Marks: _____

Primary Disability and/or Mental Illness: _____

Secondary Disability and/or Mental Illness: _____

Other presenting Disabilities or Mental Illnesses:_____

_____

2. FAMILY IDENTIFYING INFORMATION:

Mother's Name: _____ Father's Name: _____

Deceased/Living: _____ Deceased/Living: _____

Home Address: _____ Home Address: _____

_____ _____

Telephone # _____ Telephone # _____

Occupation: _____ Occupation: _____

If natural parents are deceased, who is the applicant's advocate/ correspondent?

Name: _____ Relationship: _____

3. Advocate INFORMATION:

1.) Name: _____ Age: _____

Address: _____

Telephone: ( ) _____

2.) Name: _____ Age: _____

Address: _____

Telephone: ( ) _____

4. PREVIOUS RESIDENTIAL & DAY PROGRAM HISTORY (including family home, own apartment, group home, etc…):

Name of Facility (Private or State Operated)	Address	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly explain why you would like to join our day socialization program: _____

_____

_____

_____

5. MEDICAL INFORMATION

Please describe applicant's general health history, including any serious illnesses, operations or ongoing illnesses: _____

_____

_____

_____

Does applicant have food, insect or other acute allergies? _____

Describe:_____

Does the applicant have drug allergies? Yes_____ No_____

Describe: _____

Please provide a complete list of daily medications below (use a separate sheet if necessary):

Medication	Purpose	Dosage/ Frequency	Prescribed by: (MD's Name & Specialty)

_____ _____ _____ _____

History of medical illness, developmental or physical disabilities:

Does applicant have:

Speech/Language Problems: Yes_____ No_____

Visual Impairment: Yes_____ No_____

Hearing Difficulties: Yes_____ No_____

Hypertension: Yes_____ No_____

Cardiac Problems: Yes_____ No_____

Major Ambulating Problem: Yes_____ No_____

Describe all marked Yes: _____
_____
_____

Other medical conditions? __ Please describe: _____

_____

Please note: A medical clearance form will need to be signed by your doctor in order to participate in our program.

6. EMOTIONAL/BEHAVIORAL INFORMATION:

Has applicant had a professional psychological evaluation? ___ If yes, by whom?

_____
Doctor's Name Address Phone #

Diagnosis _____

Is applicant under the care of a psychiatrist, psychologist, psychiatric social worker or mental health clinician?_____ If yes, please give details below:

Name of Clinician(s)	Address	Telephone	Date

Has applicant ever received inpatient psychiatric hospitalization? ___ If yes, please give details below:

Name of Hospital	Address/Phone	Dates	Treating Psychiatrist

Has applicant ever participated in a psychiatric day-treatment program? __If yes, please give details below.

Name of Program	Address/Phone	Dates	Program Director

7. INDEPENDENT LIVING SKILLS

Please check off true statements:

_____ Can use the restroom without assistance.
_____ Controls own money and makes purchases independently with cash or a card.
_____ Travel independently or with little assistance.
_____ Safe in unfamiliar locations.
_____ Can stay with a group in public.
_____ Knows how to be socially appropriate in public with friends and/or partners.
_____ Has a history of and habit of swearing, yelling and disrupting groups at others.
_____ Has a history of engaging in physical or emotional harm towards others.
_____ Does not engage in property destruction or self-injurious behaviors.
_____ Needs verbal prompting in order to complete tasks.
_____ Runs away or leaves when upset.
_____ Can evacuate from a fire without physical assistance.
_____ Does not make false accusations.
_____ Exhibits excessive habits (smoking, talking, pacing, ticks).
_____ Does not have a history of predatory behaviors of a sexual nature.

____ Recent history of Chemical Dependency.

Please explain any unchecked items listed above: _____

_____

_____

_____

Please describe applicant's favorite activities: (hobbies, games, sports, etc.)

_____

_____

_____

_____

What activities does the applicant dislike? _____

_____

Does applicant require any special attention in a specific area? _____

_____

Does applicant have any special food requirements? _____

_____

9. FINANCIAL INFORMATION: Please list the person below who will be covering the cost of the day socialization program.

Name:_____ Address: _____

Phone: ( ) _____ Relationship to Applicant:_____

Signature:_____ Date:_____

10. LEGAL INFORMATION:

Does Applicant have court appointed Legal Guardian? **Please Include Copy of Applicable Legal Documents.** Yes ____ No ___

Name: _____ Telephone: ( ) _____

Address: _____

County of Appointment _____

Type of Guardianship _____plenary _____partial

If partial, list powers _____

_____

Is there a stand-by or co-guardian?_____

Name: _____

Address: _____

Phone: ( )_____

Relationship to applicant _____

11. EMERGENCY CONTACTS:

1. Name:_____ Relationship:_____

Phone ( )_____

Address:_____

2. Name:_____ Relationship: _____

Phone ( )_____

Address:_____

3. Name:_____ Relationship:_____

Phone ( )_____

Address:_____

Service Waiver: I understand that my participation in LJRFS' Day Socialization Program is an at-will relationship on both the participants side, and by LJRFS. Inappropriate social behavior, abuse, non-payment, group disruptions or a change in physical or mental status are grounds for temporary or complete dismissal from the LJRFS Day Socialization Program at our discretion. Any participant asked to leave, will not be refunded membership fees, daily fees, special program fees or prepaid class fees. Any participant that is asked to leave for the day must do so in a timely fashion.

Required for Enrollment:

Sexual Predator Check Completed.
Applicant must be under the care of a psychiatrist (If applicable).
Most recent Psychiatric Evaluation or a recommendation letter should one not exist (if applicable).

By signing this application, I acknowledge that I have been informed of the various fees charged for programs operated by the Levine Jewish Residential and Family Service.

PLEASE REMIT APPLICATION FEE OF $100.00 PAYABLE TO LEVINE JEWISH RESIDENTIAL & FAMILY SERVICE, INC.

Day Socialization Program

Application Fee		**$100.00**
Daily Program Fee		**$75.00**
Additional Materials Fee		**Varies based on class**
Day Trip Fees		**Varies, participant brings funding to trip**

I grant permission for all named agencies and private industries to release information to Jewish Residential and Family Service, Inc., to be held in confidence by Jewish Residential and Family Service, Inc.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Parent/Guardian/or Responsible Party Date (if applicable)

Relationship to Applicant:_____