Rivershealth, LLC
Application and Admission Packet

Applicant Name: _____

Source of Referral **(**Parent, Guardian, CSB, FAPT, etc.): _____

Contact Name: _____

Contact Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

Services applying for (residential, home based, day support):

_____ψψ___

Applicant Information

Name: _____ SSN: _____
Last First Middle

Current Residence: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Guardian: _____

Name of Authorized Representative: _____

Address of Authorized Representative: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____

Address: _____Phone: (_____) _____

City: _____ State: _____ Zip Code: _____

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Insurance: Type: _____ ID number: _____

2nd Insurance: Type: _____ ID number: _____

Need for Services

Diagnoses:

_____ψψψψψψψ__

Behavioral Functioning:

_____

Current Supports being utilized:

_____ψ

Why are additional supports needed now?

_____ψ

History of Occupational or Physical Therapy:

_____

History of Psychiatric Hospitalizations:

_____

Strengths/ interests of the applicant:

_____

Current Physician: _____ Phone: (_____) _____

Address: _____ Fax: (_____) _____

Current Dentist: _____ Phone: (_____) _____

Address: _____ Fax: (_____) _____

Current Psychiatrist: _____ Phone: (_____) _____

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Address: _____ Fax: (_____) _____

Current Therapist: _____ Phone: (_____) _____

Address: _____ Fax: (_____) _____

Medical Information

Recent physical complaints of the applicant:

_____

Handicaps and/or restrictions on activities, including difficulties with communication:

_____

Food, drug, and other allergies:

_____

Significant illnesses and chronic conditions of the applicant:

_____

Current and past communicable diseases:

_____

Current and past serious injuries:

_____

Hospitalizations:

_____

Sexual health and reproductive history:

_____

Significant illness and chronic conditions of the applicant's family or other significant others:

_____

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History of Drug Abuse:

_____

Medications:

_____

Educational/Vocational History

Last grade completed by applicant: _____ Date of completion: _____

Type: Regular Classroom ☐ LD ☐ ED ☐ Homebound ☐

School: _____

Vocational Training: _____

Employment History:

_____

Volunteer work participated in by applicant:

_____

Quarterly Dates: _____

Service Plan Start and End Dates: _____

Legal Issues

Current or past legal charges:

_____

Other legal considerations that apply:

Payee: ☐ Legally Authorized Representative: ☐

Living Will or other Advance Directives π ¸Ŝăκb2: _____

Describe:

_____

Financial Status

Average earned monthly income: _____

Sources of income:

_____
Other entitlements:

_____

Family Status

Mother's Name: _____

Address: _____Phone: (_____) _____

City: _____ State: _____ Zip Code: _____

Father's Name: _____

Address (if different): _____Phone: (_____) _____

City: _____ State: _____ Zip Code: _____

Siblings name and age:

_____
Name of other involved family or friends:

_____

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Please attach copies of the following:

- ID Card
- Birth Certificate
- Medicaid/Medicare Card
- SS Card
- Voters Registration Card
- Secondary Insurance
- Current Psychological

Clear Form | Print | Save | Email

If you get a dialog box for check names, click OK.