CLIENT APPLICATION

Because each applicant is unique, Beyond Care Adult Day Center needs to learn how to best serve and care for all our clients. All the applicant's information provided in this form is confidential and will be treated appropriately.

Please fill out the form thoroughly and return to us upon completion. We will evaluate the completed application when it is received and contact you with appropriate information as soon as possible. Thank you for your interest in Beyond Care Adult Day Center.

Please return the application and payment to:

Beyond Care Adult Day Center
3201 FM 544,
Wylie Tx, 75098

Or you can save your application as a word document and email your application to info@beyondcareadultday.com

Applicants Personal Information

Full Name: _____

Primary Residence: Street Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Applicant's Last Name: _____

Social Security Number: _____

Height:_____ Weight: _____

Guardian Information

Father's Information

Full Name: _____

Primary Residence: Street Address: _____

Email: _____ Cell: _____
Alt #: _____

Mother's Information

Full Name: _____

Primary Residence: Street Address: _____

Email: _____ Cell: _____
Alt #: _____

Guardians' Information

Applicant's Last Name: _____

Full Name: _____

Primary Residence: Street Address: _____

Email: _____ Cell: _____
Alt #: _____

Attendance

Beyond Care Adult Day Center will offer programs Monday – Friday, from 8:00 a.m. – 2:00 p.m. We also offer extended hours from 2pm-5 pm.

Social History:

Previous programs the client has participated in: Circle all that apply.

- ☐Public School
- ☐Private School
- ☐Group Home
- ☐Independent Living
- ☐Special Needs Class or Workshop
- ☐Employment

Emergency contact

Applicant's Last Name: _____

Name: _____

Address: _____
Phone: _____
Email: _____
Relationship to Client: _____

Please use the following prompts and questions to provide us with a better understanding of the applicant and his/her characteristics and abilities. Feel free to use the back of the form if additional space is needed.

1. Please describe the applicant's ability to communicate with others. Does he/she use communication aides/devices? _____.
2. Does the applicant prefer to be in a group or alone? Does he/she work better with someone older or with someone of the same age?_____
3. Discuss the general emotional state of the applicant. Is he/she easily aggravated, reserved, or hyper-verbal? Are there techniques or exercises that you use to cope with these emotions?_____
4. What is the applicant's ability to help him/herself? With what routine daily task does he/she need another's help? _____
5. What are the applicant's aptitudes and strengths? What are his/her greatest interest? _____
6. Please describe what you see as the applicant's disabilities. _____
7. Are you or the client receiving government aid? If yes, please describe briefly. _____
8. Briefly give a synopsis of the client's daily routine. _____
9. What are the activities that the client enjoys most? _____
10. What activities, situations, or things does the applicant strongly dislike?_____
11. What are your hopes and goals for the applicant during his/her time with Beyond Care? Are there any milestones you would like to see the applicant reach with Beyond Care? _____

Applicant's Last Name: _____

Medical History

Preferred Hospital (In Case of Emergency):

Name: _____

Address: _____

Phone: _____

Physician Information

Name: _____

Address: _____

Phone: _____

Please list any other physician or therapist that the client sees.

_____

Allergy Information

Is the applicant on any regular medication? ☐YES ☐NO

If so, please list below.

Medication	Dosage	Frequency	Prescribed By	Date Prescribed

Applicant's Last Name: _____

Please list any medications the applicant is allergic to:
_____

Please list any other allergies the applicant has along with their typical reaction and necessary treatment. _____

Please list any dietary restrictions the client has. _____

History of Hospitalization

Has the applicant been hospitalized in the last two years? ☐Yes ☐No
Please list the physicians name and please describe the situation.
_____

Health History

If the applicant currently has or has had serious problems with any of the following issues, indicate below.

Issue	Please check is applicable	Issue	Please check if applicable
Cold/Sinus Trouble	☐	Kidney Disease	☐
Headaches	☐	Stomach Trouble	☐
Eyes	☐	Diabetes	☐
Glasses	☐	Diarrhea/Constipation	☐
Ears	☐	Incontinence	☐
Hearing	☐	Fainting Spells	☐
Chest Infections	☐	Menstrual Problems	☐
Asthma	☐	Muscle Problems	☐
Epilepsy/Seizures	☐	Neurological Problems	☐
Tuberculosis	☐	Emotional Problems	☐
Heart Trouble	☐	Psychological Problems	☐
Psychiatric Problems	☐	Falling	☐
Paralysis	☐	Skin Conditions	☐
Feeding	☐	Special Equipment/Aids	☐

Please expand upon any issues noted above. _____

Applicant's Last Name: _____

Is there any other information that you think would be helpful in assessing the fit of the applicant with Beyond Care Adult Day Center, or if you have any information that would assist Beyond Care Adult Day Center in better serving the applicant, please provide it below. Click or tap here to enter text.

Signature: _____ Date: _____

Applicant's Last Name: _____