Focus Forward™
Skills for life to ignite the future.

Application

Focus Forward promotes independence and growth to the fullest extent, based on each client's abilities. To provide the highest standard of support, the following outlines the expectations and guidelines we ask our applicants to consider:

- Can not be an elopement risk as we are active in our community
- Independent regarding toileting and changing clothes
- Independent regarding eating and cleaning up after oneself
- Does not require hands on intervention from staff to deescalate (i.e. physical aggressive behaviors)
- Able to remain with assigned group without redirection
- Follows directions and participates in activities with minimal prompting (does not self isolate)
- Demonstrates understanding on basic safety rules
- Can self-maintain and self-administer medications (*If applicable)

Our approach is centered on providing support in a way that promotes independence, autonomy, and dignity.

General Information

Applicant's Name: ____________________ Date of Birth: __________

Address: ____________________ Phone: __________

City: ____________________ Zip: __________

Parent/Guardian Names

Guardian 1: ____________________ Cell Phone: __________

Email: ____________________ Employer: __________

Work Phone: ____________________ Home Phone: __________

Guardian 2: ____________________ Cell Phone: __________

Email: ____________________ Employer: __________

Work Phone: ____________________ Home Phone: __________

Client lives with: ☐ Both guardians ☐ Guardian 1 ☐ Guardian 2 ☐ Other Please name: __________

Guardianship: ☐ No ☐ Yes (Please attach documentation.) ☐ Other Please name: __________

Physician/Therapist Information

Physician Name: ____________________ Phone: ____________________

Therapist Name: ____________________ Phone: ____________________

Seizure Information

Do you have seizures? ☐ No ☐ Yes

How long do seizures last? ____________________

Please describe the seizures: ____________________

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Date of last seizure: ____________________

Seizure response plan: ____________________

Allergy Information

Medication Allergies: ____________________

Food Allergies: ____________________

Other Allergies: ____________________

Latex Allergies/Sensitivity: ☐ No ☐ Yes

Special Diet/Dietary Needs: ____________________

Medications: ____________________

Please list all medications you take, including dosages and times: ____________________

____

Can you administer medications for yourself while at Focus Forward? ☐ No ☐ Yes

Please list and describe any other medial conditions: ____________________

Communication

Communicates Independently	☐Yes ☐No	Has hearing loss	☐Yes ☐No
Verbalizes	☐Yes ☐No	Wears hearing aid	☐Yes ☐No
Gestures	☐Yes ☐No	Writes Independently	☐Yes ☐No
Sign Language	☐Yes ☐No	Other Information:	____________________

Eating

Manages food/drinks independently ☐Yes ☐Minimal support ☐No

Other Information:

Personal Hygiene/Toileting

Independent toileting/ hygiene care ☐Yes ☐Minimal support ☐No

Other Information: ______________________________

____

Have you ever received special behavioral treatment or therapy, such as wrap-around services, or ABA (Applied Behavioral Analysis)?

☐ No ☐ Yes If yes, provide dates: ______________________________

Where were the services received? Please provide name/address.

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Describe any self-stimulatory behaviors and/or aggressive behaviors, such as rocking, head-banging, and/or verbal, physical aggression, fixation or tics, etc.

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Describe any significant behavior issues, e.g. running away, stealing, obsessions and/or compulsions, destructiveness, self-abusive, aggression (verbally/physically toward self, younger/vulnerable population, or animals, etc.)?

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When do(es) the inappropriate behavior(s) usually occur? What conditions/situations might trigger these behaviors?

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What do you do to address the negative behaviors?

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How do you respond to redirection?

Have you had a formal "behavior plan (PBSP)" in the past? If so, are you willing to work with the staff to review and modify if necessary?

Describe any issues or history of difficulties around sexuality. Are you open to working with the program staff in this area?

Do you have any emotional difficulties? Please explain.

Do you require assistance and/or adaptive equipment for mobility (i.e. walker, braces, wheelchair, etc.)?

Have you ever been treated by a psychologist, psychiatrist, counselor, or other mental health professional? If so, why?

Approximate dates seen:

Recommendations given

Additional comments

What activities/sports do you enjoy?

Describe your strengths and talents:

Attendance Days/Times: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Morning (9 a.m. - 12 p.m.) ☐ Afternoon)12 - 3 p.m.) Requested Start Date:

I hereby represent that the above information provided by me is accurate to the best of my knowledge.

Applicant Name:

Applicant Signature: Date:

Parent/Guardian Name: Date:

Parent/Guardian Signature:

Payment Method: ☐ Medicaid Waiver ☐ Private Pay (email for rates)

Medicaid Waiver Information

Focus Forward is an approved Medicaid Waiver Provider for ADT (Adult Day Training). Please supply the following information:

MedWaiver Client Name: ______________________

Support Coordinator Name: ______________________

Name & Address of Agency: ______________________

Agency Phone Number: ______________________

If accepted into our ADT program, your support coordinator must submit proof of approval in the form of a service authorization for "Adult Day Training." We will also need to receive a copy of your support plan indicating the goals you have chosen to work on while attending Focus Forward.

Client Goals/Expectations

Focus Forward is a person-centered program, so knowing what you want to achieve here and the goals you have set is essential to your success. Please list any and all goals YOU would like to work on at Focus Forward. (Please include goals listed on the your support plan as well as any other goals you feel are important to you.)

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Background Information

Are you currently employed? ______________________

If so, what hours/days? ______________________

Have you been to an ADT before (or similar program)? ______________________

If so, what hours/days? ______________________

What high school did you attend? ______________________

How did you hear about us? ______________________

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