HCS Program

Waiting List

MARY LEE FOUNDATION

Date of Received HCS Program Waiting List: _____

Name: _____ Nick Name: _____

ID #: _____ LON: _____

Provider: _____ Telephone #: _____

Cell Phone #: _____

Case Manager/: _____ Telephone #: _____
Family Member

Cell Phone #: _____

Address: _____ Telephone #: _____

_____

Emergency contact: _____ Telephone #: _____

Cell Phone #: _____

Physician's name: _____ Telephone #: _____

Address: _____

Age: _____ Date of birth: _____ Sex: ☐ Male ☐ Female Weight: _____ Height: _____
Month/Day/Year

Allergies: ☐ Yes ☐ No (If yes, please explain in detail allergy and reaction): _____

_____

_____

History of seizures? ☐ Yes ☐ No (If yes, please explain in detail how often, date of last seizure,

how long the seizure lasted and what type of seizures, any triggers) _____

_____

_____

Any dietary restrictions? ☐ Yes ☐ No (If yes, please explain.) _____

_____

Is any assistance needed for eating? ☐ Yes ☐ No (If yes, please explain.) _____

_____

_____

Any behavior problems? ☐ Yes ☐ No (If yes, please explain in detail.) _____

_____

_____

Is this person on a behavior plan? ☐ Yes ☐ No (If yes, please provide us with a copy)

Does he/she need assistance toileting? ☐ Yes ☐ No (If yes, please explain in detail.)

_____

_____

Is this person at risk to wander/leave the building without informing staff? ☐ Yes ☐ No (If yes, please explain in detail.)

_____

_____

_____

Does he/she need assistance walking or ambulating? Is he/she a fall risk? ☐ Yes ☐ No (If yes, please explain.)

_____

_____

_____

Medical History: (If yes, please explain.)

☐ Yes ☐ No Heart Disease: _____

☐ Yes ☐ No High Blood Pressure: _____

☐ Yes ☐ No Chronic Lung Disease: _____

☐ Yes ☐ No Asthma: _____

☐ Yes ☐ No Kidney Disease: _____

☐ Yes ☐ No Diabetes: _____

☐ Yes ☐ No Cancer: _____

☐ Yes ☐ No Hearing Problems: _____

☐ Yes ☐ No Visual Problems: _____

☐ Yes ☐ No Problems with Bowel or Bladder Functions: _____

☐ Yes ☐ No Stroke or TIA's: _____

☐ Yes ☐ No Recent Surgeries: _____

☐ Yes ☐ No Orthopedic Problems: _____

☐ Yes ☐ No Other: _____

Vaccines: ☐ Yes ☐ No Pneumonia Date received: _____

☐ Yes ☐ No Influenza Date received: _____

☐ Yes ☐ No Chicken Pox Date received: _____

☐ Yes ☐ No Tetanus Date received: _____

Medications and times: _____

_____

_____

Level of Supervision required:

☐ No special supervision away from facility (is able to walk away, ride the bus/STS and travel around town without staff assistance).

☐ No special supervision within facility but has the following restrictions when traveling away from the facility:_____

_____

_____

_____

☐ Within eyesight

☐ Within hearing

☐ Within arm's length

☐ Other supervision restrictions: _____

_____

_____

_____

Name of person completing application: _____

Signature: _____ Date: _____

- ❖ Please submit the ICAP booklet/Score sheet and DID (Determination of Intellectual Disability) documents to Mary Lee Foundation, HCS Service Department, with the HCS program waiting list. Thank you!

Mary Lee Foundation staff:

Name: _____

Date: _____