



6171 Kempsville Circle, Norfolk, VA 23502
757.622.2208 | 800.237.6555
saintmaryshome.org

INITIAL APPLICATION (attach a recent photo, if available)
please print

INDIVIDUAL'S INFORMATION

Name: _____
 First Middle Last Nickname

Date of Birth: _____ Race: _____

Male Female Social Security Number: _____

Medicaid Number: _____

Address: Street _____

 City _____ State _____ Zip _____

LEGAL GUARDIAN(S)

1. Name: _____

Phone: _____
 home work cell

Email: _____

2. Name: _____

Phone: _____
 home work cell

Email: _____

How did you find out about St. Mary's Home?

- Doctor Social Worker School Case Manager Hospital/Care Connection
 Friend Social Media Website Other _____

MEDICAL INFORMATION

Individual's Primary Diagnosis _____

Current prescribed medications: _____

Diet – individual eats by: Mouth Feeding Tube Both

Equipment: What medical equipment does the individual currently use? (examples – feeding pump, apnea monitor, supplemental oxygen, pulse oximetry, nebulizer)

Does the individual have a tracheostomy? yes no

SENSORY INFORMATION

Is the individual sensitive to (check all that apply):

noise sounds light touch movement/handling

Is the individual easily upset? yes no

Is the individual slow to calm? yes no

If yes, what triggers the upset and what works to calm the individual? _____

Does the individual have any difficulty tolerating any part of the daily routine? (examples – dressing, bathing, handling, feeding, mouth care, etc.) yes no

If yes, please describe: _____

Does the individual have self-stimulation behaviors? (examples – rocking, hitting self, biting self, repetitive actions, screaming) yes no

If yes, please describe: _____

Does the individual hit others? yes no

Does the individual injure others by any other means? yes no

If yes, please describe: _____

Does the individual take (or has ever taken) medication to help with behavior? yes no

Does the individual chew on inappropriate items? (examples – bedding, clothes, equipment)
 yes no

Are the behaviors listed above predictable unpredictable

Does the individual need (or has ever needed) any devices to control behavior? (examples – arm/elbow splints, helmet, mitts, gloves) yes no

If yes, please describe: _____

When are/were these used? _____

Are/were they effective? yes no

Does the individual have (or has ever had) skin irritation to hands from mouthing? yes no

MOBILITY INFORMATION

Does the individual move independently around the house? yes no

If yes: walking crawling/creeping

Please describe any other means of independent mobility: _____

INSURANCE INFORMATION:

Company: _____

Name on Policy: _____

Policy #: _____ Group #: _____

Consent to take photographs of applicant during the pre-admission process:

yes no

Printed name of legal guardian

Signature

Date

Printed name of legal guardian

Signature

Date

For office use only

Application received by

Date