Habilitation Assistance Corporation
ADMISSION REQUIREMENT CHECKLIST

Applicant Name: _____

Access Center Location: _____

	Please check when in place
Interdisciplinary Team Pre-Admission Review	
Fully Completed Admission Application with attachments	
Guardian Decree/Rogers Monitor	
Signed Program Agreement	
Media Release	
Recent DHSP, ISP or IEP and Comprehensive Evaluations	
Current copy of MassHealth card	
MassHealth Permission to Share Information	
Records from past admissions (i.e. state school, day program, residential/educational program)	
Pre-Admission Physical Exam (within 12 months prior to admission)	
Record of all past and present immunizations and diagnostic tests (including TB)	
Physician's approval for day habilitation services	
If resident of nursing facility, PASAAR	
Other noted below:	

Name: _____

Title: _____

Date of Completion: _____

Rev: 5-2017
Est:

HABILITATION ASSISTANCE CORPORATION

Where It All Comes Together for a Better Future

Admission Application for Day Habilitation Services

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HABILITATION ASSISTANCE CORPORATION

Admission Application for Day Habilitation Services

Section I - GENERAL INFORMATION

Full Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Gender: ☐Male ☐Female

Race: _____

Religion: _____

Date of Birth: _____

City of Birth: _____

Hospital: _____

Marital Status: _____

Language Spoken: _____

Language Understood: _____

Height: _____

Weight: _____

Hair Color: _____

Eye Color: _____

Identifying Marks: _____

_____

MassHealth Identification #: _____

Other: _____

Legally Competent? ☐Yes ☐No

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If No, Name of Legal Guardian: _____

Date of Court Confirmation: _____

Relationship to Applicant: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Emergency Contact Name: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Alternate Contact Name: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Transportation Contact Name: _____

Phone: _____ Monitor Needed (Y/N)_____

Dimensions of Wheelchair (if applicable)_____

Transportation Pickup/Dropoff Address and Type: _____

_____

Alternate Pickup/Dropoff Address and Type: _____

_____

Additional Transportation Needs: _____

Does individual live independently (Y/N)? _____ Can ride single trip (Y/N)? _____

Can be left alone at residence (Y/N)? _____

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Section II - FAMILY HISTORY

Mother: ☐Living ☐Deceased Date of Birth: _____

Full Name: _____

Address: _____

City, State, Zip: _____

Employer: _____

Employer Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Father: ☐Living ☐Deceased Date of Birth: _____

Full Name: _____

Address: _____

City, State, Zip: _____

Employer: _____

Employer Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Siblings:

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Email Address: _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Email Address: _____

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Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Email Address: _____

Family Contact:

How often is family in contact with applicant? What family members? _____

_____

Family Medical History:

Condition	*Yes*	*No*	*Relation*	*Comments*
High Blood Pressure	☐	☐		
Heart Disease	☐	☐		
Kidney Disease	☐	☐		
GI Disturbances	☐	☐		
Blood Abnormalities	☐	☐		
Tuberculosis	☐	☐		
Epilepsy	☐	☐		
Diabetes	☐	☐		
Cancer	☐	☐		
Birth Defects	☐	☐		
Intellectual Disability	☐	☐		
Psychiatric Disorder	☐	☐		
Chemical Dependency (i.e. tobacco, alcohol, drugs)	☐	☐		

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Section III – MEDICAL PROFILE

Condition	Yes	No	Condition	Yes	No
Scarlet Fever	☐	☐	Asthma	☐	☐
Diphtheria	☐	☐	Hay Fever	☐	☐
Meningitis	☐	☐	Frequent Colds	☐	☐
Rheumatic Fever	☐	☐	Headaches	☐	☐
Mumps	☐	☐	Heart Disease	☐	☐
Whooping cough	☐	☐	Arthritis/Joint Disease	☐	☐
Tuberculosis	☐	☐	Diabetes	☐	☐
Syphilis	☐	☐	GI Disturbances	☐	☐
Gonorrhea	☐	☐	Thyroid Disease	☐	☐
Pneumonia	☐	☐	Weakness	☐	☐
Cancer	☐	☐	Difficulty with Sight	☐	☐
Encephalitis	☐	☐	Difficulty with Hearing	☐	☐
Measles	☐	☐	Bladder/Kidney Disease	☐	☐
German Measles	☐	☐	Hepatitis	☐	☐
Chicken Pox	☐	☐	Herpes	☐	☐
Infect. Mono.	☐	☐	Bowel Problems	☐	☐
Other Disabilities: _____				☐	☐

Explain any of the above conditions, if necessary: _____

_____

Seizure History: (completed even if seizures are presently under control) _____

_____

Date of First Seizure: _____

Date of Last Seizure: _____

Describe seizures, i.e. body movements, duration: _____

_____

Frequency of seizures (i.e. 3-4 per day, 1-2 per month): _____

Current seizure medication: _____

Physician managing seizure: _____

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Chemical Dependency History:

Does applicant use tobacco products? ☐Yes ☐No

If yes, please specify the type and frequency and supervision needed: _____

_____

Does applicant consume alcoholic beverages? ☐Yes ☐No

If yes, please specify the amount and frequency: _____

Does applicant have any history of illegal drug use? ☐Yes ☐No

If yes, what type? _____

Has applicant received any treatment for chemical dependency? ☐Yes ☐No

Please specify: _____

Other Medications: (include name, dosage, reason for use, length of use) _____

_____

Allergies:

Medication: _____

Food: _____

Other: _____

Former Hospitalizations/Operations: _____

_____

_____

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Admission Application for Day Habilitation Services

Section IV – ASSESSMENTS

Please attach any documentation, forms or recent reports.

Primary Physician:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Neurologist:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Psychologist:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Psychiatrist:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

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Ophthalmologist:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Audiologist:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Dental:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Physical Therapy:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

Occupational Therapy:
Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

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Speech Therapy:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Last Visit: _____

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Section V – SELF-HELP & COMMUNITY SKILLS

Please briefly describe the following:

Communication (verbal, sign, gestures, etc.):

Expressive: _____

_____

Receptive: _____

_____

Eating:

Food preparation: _____

_____

Supervision Needed: _____

Special Diet: _____

Personal Hygiene: What assistance needed?

Using toilet: _____

Washing hands: _____

Brushing teeth: _____

Dressing: _____

Mobility:

Does person walk? _____

Can person ride in a van? _____

Does person require any special consideration for transportation?

_____

Likes (items, activities):

_____

_____

Dislikes (items, activities):

_____

_____

Social Interactions with Others (describe in general):

_____

_____

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Section VI – BEHAVIORAL ISSUES

Please forward a copy of recent psychological evaluation.

Is the individual at risk to self or others? Identify any known fears, behaviors, disciplinary problems. Describe as accurately as possible; if additional space is required, use the back of this sheet or additional sheets.

Behavior programs: (past/present; known behavioral antecedents; identify reinforcers)

General attitudes and motivation:

HABILITATION ASSISTANCE CORPORATION

Admission Application for Day Habilitation Services

Section VII – EDUCATIONAL/WORK PLACEMENTS

Educational History:

Please list all schools attended and grades completed.

School	Address	Years Attended

Vocational/Day Program History/Competitive Employment:

Please list all programs beginning with the most recent.

Name	Address	Years Attended	Description of Services

Residential History:

Residence	Address	Years Resided

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Admission Application for Day Habilitation Services

Section VIII – SUMMARY REPORT

Please indicate reason(s) for referral, projected length of stay, and anticipated goals and objectives. _____

_____

_____

Attachments:
☐Copy of MassHealth Card
☐Comprehensive Evaluation (i.e. IEP, ISP, assessments from another day program)
☐Physical Examination within 12 months of application
☐If Nursing Home Resident, PASSAR and letter recommending specialized services
☐Psychological Evaluation
☐Roger's Monitor Documentation (if applicable)
☐Immunization Record (including TB testing)
☐Guardianship Documentation
☐Signed Program Agreement
☐Media Release
☐Physician's Approval for Day Habilitation and Gym Equipment
☐MassHealth Permission to Share Information

Signature of Applicant:: _____

Signature of Parent/Guardian: _____

Signature of Other/Title: _____

Date of Completion: _____

Please note the first 30 days of admission is a period of assessment to determine permanent placement in the program.

ANNUAL PHYSICAL EXAMINATION FORM – PAGE 1 OF 2

Massachusetts Department of Developmental Services

Name:					**Date:**	
Vital Signs:	Ht	Wt	T°	BP	P	R

General Appearance:	
Skin:	
HEENT: Head	
Eyes/Vision Screen	
Ears/Hearing Screen	
Mouth/Throat	
Neck:	
Chest:	
Breast:	
Heart:	
Lungs:	
Abdomen:	
Genitalia: GYN/Testicular Exam	
Rectum:	
Musculoskeletal: Back/Spine	
Extremities	
Lymph Nodes:	
Circulatory:	
Neurologic: Cranial Nerves	
Reflexes	
Sensory	
Motor	
Cognitive	
Other:	

HC Provider Signature: _____

National Provider Identifier Number: _____

ANNUAL PHYSICAL EXAMINATION FORM – PAGE 2 OF 2

Addendum to Massachusetts Department of Developmental Services Form
Habilitation Assistance Corporation

Patient Name: **Date:**

DO YOU APPROVE DAY HABILITATION SERVICES FOR THIS INDIVIDUAL?

YES **NO**

PLEASE LIST ALL ALLERGIES:

ARE THERE ANY DIETARY RESTRICTIONS FOR THIS PERSON?

YES **NO**

If yes, what are the dietary restrictions?

DO YOU APPROVE THE FOLLOWING HEALTH CLUB EQUIPMENT?

Upright Stationary Bicycle	YES	NO
Upright Stairstepper	YES	NO
Recumbent Bicycle	YES	NO
Pool/Aquatics	YES	NO

Treadmill	YES	NO
Universal	YES	NO
Recumbent Stairstepper	YES	NO
Elliptical	YES	NO

LIST ANY PHYSICAL ACTIVITY IN WHICH THIS PERSON SHOULD NOT ENGAGE:

HAVE CURRENT MEDICATIONS BEEN REVIEWED AND CONTINUE TO BE CLINICALLY INDICATED?

YES **NO**

HC PROVIDER SIGNATURE _____ DATE_____

National Provider Identifier Number _____

HABILITATION ASSISTANCE CORPORATION

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MEDIA RELEASE FORM

Habilitation Assistance Corporation (HAC) is committed to protecting the privacy of the individuals we serve. That is why we require consent before displaying images of an individual in our professional presentations or website, or in other HAC media.

We have found that positive images of the people we support, promoting their skills, talents and accomplishments, can help educate the public and can further contribute to a member's development and success. The Graphics Committee at HAC works to respectfully and professionally include the images of consenting members in its program presentations and in other appropriate HAC media.

Please indicate your consent preference below. *If you choose "yes" you may rescind this release at any time by notifying HAC in writing, except to the extent that HAC has already acted in reliance upon it. The release is otherwise effective for so long as HAC continues its operations.*

Program Location: _____

Participant's Name: _____

☐ **YES, the undersigned grants HAC permission to include _____'s image or likeness in any form of media including but not limited to color slides, video programs, motion pictures, photographs, and printed materials, and to display or transmit such image by any means including, without limitation, in HAC program presentations, on HAC's website/Facebook page, or on other HAC promotional materials.**

☐ **NO, thank you. The undersigned requests that _____ NOT be included in any media as described above.**

Signature of Individual: _____

Signature of Legal Guardian: _____

Date: _____

*** Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by the federal privacy regulations*

Rev: 10-2014, 5-2017