Application & Admission Procedures

FASD Communities
National Headquarters
1516 Avon Way
Honolulu, HI 96822

APPLICATION

1. Complete the following forms:
   a. Application form (Including Expectations of Parents/Caregivers)
   b. Sign "Release of Information" form
   c. Sign "Medical and Extended Care" agreement
   d. Sign the waver

2. A complete medical history is to be included with the application along with the psychological evaluations from school/or other sources, and vocational reports. The Screening Committee may request that an applicant have a psychological evaluation and/or a vocational assessment if these are not available or have become outdated.

3. Include recent color photograph of applicant. (An inexpensive snapshot is fine)

4. Return application to FASD Communities along with a NON-REFUNDABLE $50.00 (fifty dollar) application fee for each application form submitted.

5. Please DO NOT Staple papers together when returning application and supporting documents.

6. The application will be reviewed by the Executive Director to determine the compatibility for placement at a FASD Community. The applicant and parent or guardian will be notified of the decision.

ADMISSION

1. If the Screening Committee determines that the applicant is a candidate for placement, a phone interview will take place as soon as possible.

2. Following the interview, the Screening Committee will assess the applicant's compatibility and make a determination regarding a two-day visit to the FASD Community.

3. If the applicant is accepted for the two-day period, arrangements will be made for the date of arrival and a list of things the applicant will need to bring with them. The parents /guardians will be contacted for permission to extend the two-week period if necessary.

4. The following requirements must be met before the applicant moves to the FASD Community:

    a. Physical and dental examinations (within six months)

    b. A satisfactory method of payment is to be established. Currently the monthly cost of care as established by the Board of Directors for FASD Communities is $4,000.00. (The goal of sustainability for the FASD Community is 4-5 years after opening.)

    c. Any requirements concerning medication, special treatment or diet, etc. must be in writing (with a physician's note if possible) and medication should accompany the candidate.

5. Upon arrival, the applicant is received for a **6-MONTH** trial period. At the end of this period, a written staff evaluation is shared with the applicant and parent or guardian. At this time, a determination of initial acceptance of the individual is put forth. Following an extended period of 90 days, the final determination is made and shared with the applicant and parent of guardian.

PURPOSE of FASD COMMUNITIES

The purpose of FASD Communities is to provide structured, supportive housing, ongoing mentoring and employment, along with predictable daily routines in a family atmosphere to young adults with Fetal Alcohol Spectrum Disorders. In doing so, FASD Communities will create a safe, sustainable living environment where its residents can reach their full emotional, intellectual, social, and vocational potential through interaction with and support from well-trained staff and the local community.

We are not a faith-based organization though attendance at houses of worship is supported. FASD Communities welcomes applicants from all religious, ethnic, and cultural backgrounds.

MAIL APPLICATION FOR ADMISSION to: FASD Communities

National Headquarters

1516 Avon Way

Honolulu, HI 96822

Please note: The following forms ask for information that is vitally important, particularly if an applicant is selected for placement. We ask that you carefully consider all of the questions and answer them truthfully. Any falsification of information will be sufficient cause for disqualification or dismissal.

APPLICANT_____DATE:_____

ADDRESS_____

_____TELEPHONE:_(___)_____

SOCIAL SECURITY NUMBER:_____-_____-_____

DATE OF BIRTH:_____

Male [ ] Female [ ] Place of Birth_____

Does applicant take any medications? [ ]Yes [ ]No

If yes, list medications: _____

_____

_____

_____

_____

Is applicant's primary medical diagnosis a FASD?

Other diagnoses?

Explain_____

_____

FAMILY OF APPLICANT

Father's Name:_____

Address:_____ Telephone: (__)_____

Employer:_____ Business phone: (__)_____

Mother's Name:_____

Address:_____

_____ Telephone: (__)_____

Employer:_____ Business phone: (___)_____

Legal Guardian's Name:_____

Address:_____

_____ Telephone: (___)_____

Employer:_____ Business phone: (___)_____

Relationship_____

Give name, age and address of brothers and/or sisters of applicant:

Name	**Age**	**Address**	**Telephone**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

APPLICANT'S PHYSICAL DESCRIPTION:

Present height:_____

Present weight:_____

Difficulty with vision: Yes [ ] No [ ] If yes, describe:

_____

Difficulty with hearing: Yes [ ] No [ ] If yes, describe:

_____

COORDINATION: (Check One)

Gross motor coordination…….[ ] Excellent [ ] Good [ ] Fair [ ]Poor

Fine motor coordination……..[ ] Excellent [ ] Good [ ] Fair [ ]Poor

Walks independently……[ ] Excellent [ ] Good [ ] Fair [ ]Poor

Walks up and down stairs……[ ] Excellent [ ] Good [ ] Fair [ ]Poor

Runs……[ ] Excellent [ ] Good [ ] Fair [ ]Poor

Rides bicycle……[ ] Excellent [ ] Good [ ] Fair [ ]Poor

(If applicable) Physical limitations:

_____

Comments:_____

_____

COMPREHENSION: (Check One)

Understanding……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Follows basic directions……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Answers basic questions……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor

Comments:_____
_____

SELF CARE: (Check One)

Eating:

Eats family style……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Uses fork……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Uses spoon……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor

Comments:_____
_____

Dressing:

Dresses self……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Cares for clothes……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Selects clothes……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Changes clothes as needed……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor

Comments:_____
_____

Personal:

Brushes teeth……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Flosses teeth……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Uses deodorant……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Shampoos hair……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor
Grooms hair……	[ ] Excellent	[ ] Good	[ ] Fair	[ ]Poor

Shaves…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Washes hands…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Takes bath/shower alone…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Uses toilet paper…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Comments:_____
_____

HOUSEKEEPING:

Cleans room…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Makes bed…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Washes clothes.…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Puts clothes away…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Washes dishes…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Dries dishes…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Sets and clears the table…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Vacuums carpets…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Dusts furniture, etc…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Sweeps floors…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Wet mops the floor…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Empties the trash…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Shovels snow…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Irons clothing…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Mends clothing…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Mows lawn…… [ ] Excellent [ ] Good [ ] Fair [ ]Poor

Comments:_____
_____

PROBLEM BEHAVIORS: (Check any that apply)

[ ] Argues

[ ] Self-injurious behavior

[ ] Non-compliance

[ ] Physically aggressive (towards others)

[ ] Physically aggressive (towards property)

[ ] Innapropriate sexual behavior

[ ] Swears

[ ] Steals

[ ] Lies

[ ] Bosses others

[ ] Runs away

[ ] Wets bed

[ ] Up at night

Please describe the individual's most significant inappropriate behaviors and describe past drug/alcohol use and or criminal charges if applicable:

_____
_____
_____
_____
_____
_____
_____
_____

If individual underwent treatment for drug/alcohol abuse, please explain:

_____
_____
_____

_____
_____

MONEY MANAGEMENT:

Understands money……. [ ] Yes [ ] No

Gives next dollar over amount…….. [ ] Yes [ ] No

Pays exact amounts…….. [ ] Yes [ ] No

Uses checkbook…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Buys personal items…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Shops in store…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Withdraws & deposits money in bank…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Comments:_____
_____

SOCIALIZATION AND COMMUNITY SKILLS:

Maintains appropriate social distance…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Offers assistance to others…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Shows consideration of others feelings… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Gets along well with same sex peers..…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Gets along with opposite sex peers……. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Accepts constructive criticism…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Is willing to help when asked…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Assumes responsibility when asked……. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

INDEPENDENCE:

Can give name and other contact info…. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Operates home appliances safely…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Uses telephone…….. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Recognizes need for medical services..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Seeks medical help in emergencies..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Recognizes vital signs in another..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Takes own medication..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Sets alarm clock for getting up on time... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Goes to bed at required time..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Keeps perishable food for safe lengths.... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Fixes breakfast and lunch for self..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Fixes at least 2 different evening meals.... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Safely uses a sharp kitchen knife..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Does home repair and maintenance..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Uses electric equipment (drill, saw,...)..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Uses sewing machine..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Uses washer/dryer..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Has knowledge of fire safety..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Leaves Building at sound of fire alarm..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Has a valid Driver's License..... [ ] yes [ ] No

Has a good driving record..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Comments:_____
_____

ACTIVITIES & INTERESTS:

Initiates hobbies during "free time"..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Participates in leisure activities..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Enjoys going on outings ..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Feels comfortable around animals..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Likes the out-of-doors…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Enjoys gardening…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Has worked in a garden…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Knows how to swim…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Comments:_____

_____

Applicants indoor interests are: _____

_____

Applicants outdoor interests are: _____

_____

ACADEMIC:

Tell time to the minute…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Tells time to 15 minutes…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Knows basic math…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Uses a calculator…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Can read…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Can write…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Can communicate a message by phone.. [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Can write a message taken by phone…... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Can apply number concepts up to ten.... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Can apply number concepts beyond ten [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Comments:_____

_____

MEDICAL CARE:

1. Physician's name, address: _____

_____ Telephone: (___)_____

Date of last physical: _____ Visit: _____

Results: _____

2. Dentist's name, address _____

_____ Telephone: (___)_____

Date of last exam: _____

Results: _____

Does applicant currently require any dental work? [ ] Yes [ ] No

Explain_____

3. Eye doctor's name, address: _____

_____ Telephone: (__)_____

Date of last exam: _____

Results: _____

Wears glasses? [ ] Yes [ ] No……All the time? [ ] Yes [ ] No

Wears contacts? [ ] Yes [ ] No……All the time? [ ] Yes [ ] No

If yes, reason for wearing glasses and/or lenses: _____

Sight with glasses/lenses…… [ ] Excellent [ ] Good [ ] Fair [ ] Poor

4. Hearing doctor's name, address: _____

_____ Telephone: (__)_____

Date of last exam: _____

Results: _____

Does applicant wear hearing aids?.....[ ] Yes [ ] No

Hearing with aids?..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

INSURANCE:

Hospitalization Insurance…… [ ] Yes [ ] No

If Yes, name of company: _____

Policy No. _____

Medical/Health Insurance?..... [ ] Yes [ ] No

If Yes, name of company: _____

Policy No. _____

Will insurance cover dental and/or eye needs? [ ] Yes [ ] No

Additional medical information: _____

_____

_____

MEDICAL HISTORY:

PART 1

Present health condition..... [ ] Excellent [ ] Good [ ] Fair [ ] Poor

For the following, please indicate with a **P** for a past condition, **C** for a continuing condition and an **N** for never:

Eyes:

Eye disease __ Eye injury __ Impaired sight __

Ear disease __ Ear injury __ Impaired hearing __

Nose/throat:

Sinuses __ Throat __ Nose Trouble __ Other __

Fainting spells __ Convulsions __ Loss of consciousness __

Paralysis __ Frequent or severe headaches __ Dizziness __

Depression or anxiety __ Hallucinations __

Enlarged Glands __ Goiter or enlarged thyroid __

Skin disease (name) _____

Chronic or frequent cough __ Chest pain or angina pectoris __

Spitting up of blood __ Night sweats __

Shortness of breath __ Palpitation or fluttering heart __

Varicose veins __ Swelling of hands, feet or ankles

Extreme tiredness or weakness _____ Explain: _____

_____

Kidney disease or stones __ Bladder disease __ Bladder infection __

Albumin-sugar-pus-etc. in urine __ Difficulty in urinating __ Incontinence __

Stomach trouble or ulcers __ Indigestion __ Liver or gallbladder disease __

Colitis or other bowel disease (name): _____

Appendicitis __

Hemorrhoids or rectal bleeding __ Constipation or diarrhea __

Other: _____

_____

Comments or Concerns: _____

_____

PART 2:

Medications:

Does the applicant take any prescribed drugs? [ ] Yes [ ] No

Please name them and give amounts and directions for taking them:

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Does the applicant take any other medications, supplements or vitamins regularly or frequently?

[ ] Yes [ ] No

If Yes, please name them: _____

_____

Known allergic reactions to medications? [ ] Yes [ ] No

If Yes, please name them: _____

_____

Does the applicant administer own medication? [ ] Yes [ ] No

PART 3

Cause of Developmental Disability if known: _____

_____

PART 4:

Injuries: Give type and date of injury:

Broken bones?.....[ ] Yes [ ] No _____

Sprain or dislocation?.....[ ] Yes [ ] No _____

Lacerations (extensive) ?.....[ ] Yes [ ] No _____

Concussions or head injuries?..[ ] Yes [ ] No _____

Lost consciousness?.....[ ] Yes [ ] No Explain: _____

Please explain in detail any other injuries: _____

_____

PART 5

Examinations & Tests:

Any x-rays in last five years? [ ] Yes [ ] No

Physician's name, address: _____

_____Telephone: (__)_____

Results: _____

Surgery & treatments: **Give details:**

Tonsillectomy [ ] Yes [ ] No _____

Appendectomy [ ] Yes [ ] No _____

Hernia [ ] Yes [ ] No _____

Transfusion (blood or plasma) [ ] Yes [ ] No If yes, explain: _____

Blood type (if known) ____ Hemophiliac [ ] Yes [ ] No

Any other operations? [ ] Yes [ ] No If Yes, explain: _____

_____

Has the applicant ever been advised to have any surgical operation which has not been done?

[ ] Yes [ ] No If Yes, explain: _____

PART 6

Psychological Information:

Has the applicant ever had a psychological evaluation? [ ] Yes [ ] No

If Yes, date of evaluation: _____(Mo/yr) Name of evaluator: _____

Other doctors (Neurologists, Pediatricians, Allergy Specialists, Chiropractors, etc)

Please give dates and details:

_____

PART 7

Personal Medical History (Please check all that apply) Dates and/ or comments:

Epilepsy (also see PART 8)……[ ] Yes [ ] No

Measles or German Measles……[ ] Yes [ ] No

Chicken pox or Mumps……[ ] Yes [ ] No

Whooping Cough……[ ] Yes [ ] No

Scarlet fever or Scarlatina……[ ] Yes [ ] No

Pneumonia or Pleurisy……[ ] Yes [ ] No

Diphtheria or Smallpox……[ ] Yes [ ] No

Influenza……[ ] Yes [ ] No

Rheumatic fever or heart disease……[ ] Yes [ ] No

Heart Murmur……[ ] Yes [ ] No

Arthritis or Rheumatism……[ ] Yes [ ] No

Any bone or joint disease……[ ] Yes [ ] No

Whooping Cough……[ ] Yes [ ] No

Neuritises or neuralgia……[ ] Yes [ ] No

Bursitis. Sciatica or lumbago……[ ] Yes [ ] No

Polio or meningitis……[ ] Yes [ ] No

Back or foot problems……[ ] Yes [ ] No

Bright's disease or kidney infection……[ ] Yes [ ] No

Gonorrhea or Syphilis……[ ] Yes [ ] No

Hepatitis……[ ] Yes [ ] No

Anemia or jaundice……[ ] Yes [ ] No

Migraine headaches……[ ] Yes [ ] No

Tuberculosis……[ ] Yes [ ] No

Diabetes or Cancer……[ ] Yes [ ] No

High or low blood pressure……[ ] Yes [ ] No

Food, chemical or drug poison……[ ] Yes [ ] No

Hay fever or Asthma……[ ] Yes [ ] No

Hives or Eczema……[ ] Yes [ ] No

Frequent colds or sore throat……[ ] Yes [ ] No

Bronchitis……[ ] Yes [ ] No

Mononucleosis……[ ] Yes [ ] No

Hernia……[ ] Yes [ ] No

Frequent infections or boils……[ ] Yes [ ] No

HIV Positive or AIDS ……[ ] Yes [ ] No

Any other diseases? [ ] Yes [ ] No If Yes, please explain: _____

_____

PART 8

Seizures:

Does the applicant have any history of seizures? [ ] Yes [ ] No

If yes, please check the type:

[ ] Generalized

[ ] Absence (also called Petit Mal)

[ ] Simple Partial (also called Jacksonian)

[ ] Complex Partial (also called Psychomotor or Temporal Lobe)

[ ] Atonic Seizures (also called Drop Attacks)

[ ] Myoclonic Seizures

[ ] Infantile Spasms

When was the last noted seizure activity? _____Mo/yr

Frequency of seizures? [ ] Daily [ ] Weekly [ ] Bi-weekly [ ] Monthly [ ] Other

Comments: _____

_____

PART 9

Immunizations: (Please check all that apply) Dates:

Smallpox……..[ ] Yes [ ] No _____

Typhoid……[ ] Yes [ ] No _____

Mantoux (TB)……[ ] Yes [ ] No _____

Diphtheria-Tetanus……[ ] Yes [ ] No _____

Polio or meningitis……[ ] Yes [ ] No _____

DPT……[ ] Yes [ ] No _____

Polio Series……[ ] Yes [ ] No _____

Measles/Mumps/Rubella……[ ] Yes [ ] No _____

Allergies: (Please check all that apply) Reaction:

Penicillin……[ ] Yes [ ] No _____

Aspirin, Codeine or Morphine……[ ] Yes [ ] No _____

Mycins or other antibiotics……[ ] Yes [ ] No _____

Merthiolate or Mercurochromes……[ ] Yes [ ] No _____

Tetanus Antitoxin or Serums……[ ] Yes [ ] No _____

Bee stings……[ ] Yes [ ] No _____

Any other drug……[ ] Yes [ ] No _____

Any other foods……[ ] Yes [ ] No _____

Adhesive tape……[ ] Yes [ ] No _____

Nail polish or other cosmetics……[ ] Yes [ ] No _____

Others (name:_____)……[ ] Yes[ ] No _____

PART 11

Diet:

Is the applicant on a special diet? [ ] Yes [ ] No

If special diet, please give reason and state type and details of diet:

_____

_____

Is there anything about the applicants eating habits we should know about, please explain:

_____

_____

PART 12 (Women Only)

Menstrual History:

Age at onset _ Flow: Heavy [ ] Medium [ ] Light [ ]

Regular_____ Irregular _____

Cycle: __days (from start to start)

Usual duration: ____days

Pain or cramps: ……[ ] Yes [ ] No

If Yes, what is usually done? _____

Ever had a Pap Smear? ……[ ] Yes [ ] No If Yes, date: _____

Was it negative? ……[ ] Yes [ ] No

Does the applicant see to her own menstrual care? [ ] Yes [ ] No

Comments:

_____

PART 13

Family History:

Father's health (if living):

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

If deceased, cause: _____Age at death: _____

Mother's health (if living):

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

If deceased, cause: _____Age at death: _____

Brother's or sister's health (if living):

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

If deceased, cause: _____Age at death: _____

Brother's or sister's health (if living):

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

If deceased, cause: _____Age at death: _____

Has any blood relative ever had:

(Please check all that apply) Who:

Epilepsy……[ ] Yes [ ] No _____

Cancer……[ ] Yes [ ] No _____

Tuberculosis……[ ] Yes [ ] No _____

Diabetes……[ ] Yes [ ] No _____

Heart Trouble……[ ] Yes [ ] No _____

High Blood Pressure……[ ] Yes [ ] No _____

Stroke……[ ] Yes [ ] No _____

Mental Illness……[.] Yes [ ] No _____

Suicide……[ ] Yes [ ] No _____

Arthritis……[ ] Yes [ ] No _____

Congenital Deformities……[ ] Yes [ ] No _____

Back Trouble……[ ] Yes [ ] No _____

Foot Problems……[ ] Yes [ ] No _____

Spasticity……[ ] Yes [ ] No _____

Cerebral Palsy……[ ] Yes [ ] No _____

EXPECTATIONS OF PARENTS AND CAREGIVERS

1. Please describe below the social, emotional, and vocational expectations that you have for your young adult who chooses to live in a FASD Community?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. FASD Community homes are set-up to be family-style environments and dating among residents is not permitted. What, if any, concerns do you have about this policy?

_____
_____
_____
_____

**********<u>**CONFIDENTIALITY**</u>**********

FASD Communities strictly adheres to the right of privacy for our residents and staff. Therefore, records for residents and staff files shall be maintained in a professional manner and with the utmost regard for confidentiality. The Director of FASD Communities is responsible for assuring that only appropriate persons have immediate access to these records. Specific information within the records may be made available to other professionals, agencies and individuals who have been authorized to have access, or review case information, either by law or with the signed consent of the individuals. Under no circumstances shall a staff member divulge

without proper authorization any information relating to a resident or staff member to parties outside the organization, or to parties inside the organization not having training or supervision responsibility for that person. To do so will result in immediate disciplinary action which may include discharge from employment.

I HEREBY CERTIFY THAT THE INFORMAITON PRESENTED ON THIS APPLICATION FORM IS TRUE, ACCURATE AND COMPLETE. ANY FASLIFICATION WILL BE SUFFICIENT CAUSE FOR DISQUALIFICATION OR DISMISSAL. REFERENCES AND PERSONAL INFORMATION WHICH BECOME A PART OF THIS RECORD WILL BE REGARDED AS CONFIDENTIAL.

_____ _____ _____

SIGNATURE DATE RELATIONSHIP TO APPLICANT

_____ _____

NOTARY PUBLIC DATE

MEDICAL & EXTENDED CARE AGREEMENT

I/we the undersigned do hereby agree to be responsible for the payment of all medical expenses (in the event that the applicant is not covered under Medicaid and/or Medicare) while he/she is a resident with FASD Communities.

_____ _____

Parent Date

_____ _____

Guardian Date

In the event of an emergency, I do hereby authorize the Director of FASD Communities, or another staff member of FASD Communities, to give consent for medical treatment for the applicant.

_____ _____

Parent Date

_____ _____

Guardian Date

FASD Communities
National Headquarters
1516 Avon Way
Honolulu, HI 96822

RELEASE OF INFORMATION

I, _____, give my consent to release any pertinent information

Regarding

_____ to FASD Communities.

Name of the Applicant

_____ _____

SIGNATURE DATE RELATIONSHIP TO APPLICANT

_____

APPLICANT SIGNATURE DATE