RAINBOW OMEGA, INC.
APPLICATION FOR ADMISSION

P.O. Box 740 Eastaboga, AL 36260

Date Application: _____

I. GENERAL INFORMATION:

A. Applicant's Identifying Data:

Applicant's Name: _____
First *Middle* *Last*

Date of Birth: _____/_____/_____

Birthplace: _____
City *County* *State*

Phone #: (_____) _____

Email Address: _____

Home Address: _____
Street *City* *State* *Zip*

Mailing Address: _____
(If different from street address)

Marital Status: ___Never Married ___Married ___Separated ___Divorced ___Widowed

B. Referral Source: Please list the name and title of the person who referred you to Rainbow Omega, Inc., (ROI) and/or how you found out about ROI: _____

_____

C. Services Requested:

___Residential Care (which includes Vocational Training)
___Vocational Training
___Intermediate Care Facility
___Day Habilitation

D. Date Placement Desired:

____ As soon as possible.
____Placement is currently not warranted but would like to start the process.
(*Please indicate the approximate time-frame when placement might be desired):* _____

_____

*****Please attach the applicant's most recent Psychological Evaluation and a recent photo. If applicant has a Legal Guardian, please attach a copy of the court order*****

(Applications will not be processed or added to a waiting list until the above documents are received by ROI).

To be completed by ROI:
Date Received Application: _____

E. **Nature of Disability**: (*i.e., Intellectual, Autism, Cerebral Palsy, Brain Injury, Down Syndrome, etc.)*_____

_____

F. **Date Diagnosed:** _____

G. **References for Applicant: (***Please list **three** individuals who have worked with the applicant or know the applicant personally).*

- **Individual #1:**

Name: _____

Home Phone #: (_____) _____ **Cell Phone #** (_____) _____

Email Address: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
(If different from street address)

Relationship: _____
(i.e., Family, Friend, Teacher, Church, School, Therapist, Physician, Other, etc.)

- **Individual #2:**

Name: _____

Home Phone #: (_____) _____ **Cell Phone #** (_____) _____

Email Address: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
(If different from street address)

Relationship: _____
(i.e., Family, Friend, Teacher, Church, School, Therapist, Physician, Other, etc.)

- **Individual #3:**

Name: _____

Home Phone #: (_____) _____ **Cell Phone #** (_____) _____

Email Address: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
(If different from street address)

Relationship: _____
(i.e., Family, Friend, Teacher, Church, School, Therapist, Physician, Other, etc.)

II. FAMILY and SOCIAL DETAILS:

A. Parent's Information:

- **Father's Name:** _____
  First Middle Last

  Home Phone #: (_____) _____ **Cell Phone #** (_____) _____
  Email Address: _____

  Street Address: _____
  Street City State Zip

  Mailing Address: _____
  (If different from street address)

  Occupation & Name of Company: _____

  If the Father is deceased, please complete the following information:
  ***Date of Death*: _____ *Age:* _____ *Cause of Death:* _____**

- **Mother's Name:** _____
  First Middle Last

  Mother's Maiden Name: _____

  Home Phone #: (_____) _____ **Cell Phone #** (_____) _____

  Email Address: _____

  Street Address: _____
  Street City State Zip

  Mailing Address: _____
  (If different from street address)

  Occupation & Name of Company: _____

  If the Mother is deceased, please complete the following information: _____
  ***Date of Death*: _____*Age:* _____*Cause of Death:* _____**

B. **Guardianship**: The Applicant has been Adjudicated/Declared Legally Incompetent? __ No __Yes
(*If the answer is **yes**, please complete the information below):*

Name of Court Appointed Legal Guardian: _____
First Middle Last

Home Phone #: (_____) _____ **Cell Phone #** (_____) _____

Email Address: _____

Street Address: _____
Street City State Zip

Mailing Address: _____

(If different from street address)

Occupation & Name of Company: _____

A. **Names of Siblings:**

#1 _____ **Date of Birth:** _____
First Middle Last

#2 _____ **Date of Birth:** _____
First Middle Last

#3 _____ **Date of Birth:** _____
First Middle Last

#4 _____ **Date of Birth:** _____
First Middle Last

#5 _____ **Date of Birth:** _____
First Middle Last

B. **Other Significant People in the Applicant's Life**:

#1 _____ **Relationship to Applicant**: _____
First Middle Last

#2 _____ **Relationship to Applicant:** _____
First Middle Last

#3 _____ **Relationship to Applicant:** _____
First Middle Last

#4 _____ **Relationship to Applicant:** _____
First Middle Last

C. Favorite Activities: _____
_____

D. **Hobbies:** _____
_____

E. **Communication Skills:** What is the Applicant's Primary Mode of Communication with Others? _____

_____

(i.e., speech, sign language, gestures, etc.)

F. **Social Interactions:** How does the Applicant interact with Friends and Family? _____

G. **Religious Affiliation:** What is the Applicant's Religious Affiliation? _____

H. **Daily Routine:** What is the Applicant's Current Schedule?

- **Morning:** *(What time does the Applicant getup?)*_____
- **Afternoon:** _____
- **Evening:** _____
- **Night:** *(What time does the Applicant go to bed?)*_____

I. **Individual Preferences:** Please list the **Applicant's Likes** and **Dislikes** in the table below:

	Likes	**Dislikes**
Food		
TV		
Music		
Sports		
Outside Activities		
Restaurants		
Games		
Other		

III. SCHOOLS and PROGRAMS:

A. Education: *(Check one)*

___ Applicant earned a High School Diploma.
___ Applicant earned a Certificate of Completion from High School.
___ Applicant is currently attending High School.

B. **Program Participation**: *(Check all situations/programs participated in by the applicant)*

_____ Group Home
_____ Independent Living
_____ State Institution
_____ Public Schools
_____ Competitive Job
_____ Rehabilitation Program
_____ Pre-Vocational Training
_____ Sheltered Workshop
_____ Day Habilitation Program
_____ Other _____

C. **Program Information:** (*Please complete the requested information for each program).*

❖ **Program #1:**

- **Name of Program:** _____
- **Type of Program:** *(Please choose one from the list above)*_____
- **Dates Attended:**_____
- **Reason for Leaving Program**: _____
- **Program Address:** _____
  Street City State Zip
- **Name of Program Contact Person:**
  _____
  First Last Title
- **Email Address for Contact Person**:_____
- **Phone #'s for Contact Person:** ***Business Phone #:*** (_____)_____
  Cell Phone #: (_____) _____

❖ **Program #2:**

- **Name of Program:** _____
- **Type of Program:** *(Please choose one from the list above)* _____
- **Dates Attended:**_____
- **Reason for Leaving Program**: _____
- **Program Address:** _____
  Street City State Zip
- **Name of Program Contact Person:**
  _____
  First Last Title

- **Email Address for Contact Person**:_____
- **Phone #'s for Contact Person:** ***Business Phone #:*** (_____) _____
  Cell Phone #: (_____) _____

IV. ACTIVITIES OF DAILY LIVING:

A. Hygiene:

1.	Showering	___ Independent	___ Needs Assistance
2.	Brushing Teeth	___ Independent	___ Needs Assistance
3.	Shaving	___ Independent	___ Needs Assistance
4.	Toileting	___ Independent	___ Needs Assistance

B. Laundry:

1.	Sorting Light Colors from Dark:	___ Independent	___ Needs Assistance
2.	Setting the Controls:	___ Independent	___ Needs Assistance
3.	Pouring in the Detergent:	___ Independent	___ Needs Assistance
4.	Folding the Clothing:	___ Independent	___ Needs Assistance
5.	Hanging up the Clothing:	___ Independent	___ Needs Assistance
6.	Folding the Towels/Wash Cloths:	___ Independent	___ Needs Assistance
7.	Putting up the Towels/Wash Cloths:	___ Independent	___ Needs Assistance

C. Dressing:

1.	Picking Out/Choosing Clothing:	___ Independent	___ Needs Assistance
2.	Putting Clothing On & Off:	___ Independent	___ Needs Assistance

D. Handling/Understanding Money

1.	Identifies Coins and Bills:	___ No	___Yes
2.	Understands the Value of Money:	___ No	___Yes
3.	Understands & Knows How to Make Purchases:	___ No	___Yes

E. Meals

1.	Holds a Spoon/Fork and Eats without Assistance:	___ No	___Yes
2.	Holds a Glass and Drinks without Assistance:	___ No	___Yes
3.	Cuts their own Food without Assistance:	___ No	___Yes

F. Preparing Food:

1.	Prepare a Simple Item like a Sandwich:	___ No	___ Ye
2.	Understands & Knows How to use a Microwave:	___ No	___ Yes
3.	Understands & Knows How to Use an Oven:	___ No	___ Yes
4.	Understands & Knows How to Use a Stove:	___ No	___ Yes

G. Chores:

1.	Keeps their Room Clean:	___No	___ Yes
2.	Sweeps the Floors:	___No	___ Yes
3.	Mops the Floors:	___No	___ Yes
4.	Dusts the Furniture:	___No	___ Yes
5.	Loads the Dishwasher:	___No	___ Yes
6.	Unloads the Dishwasher:	___No	___ Yes
7.	Cleans and Wipes the Table and Counters:	___No	___ Yes

V. VOCATIONAL TRAINING:

A. **Job Training:**

1. **The Applicant has participated in a *Job Training Program*:** ___No ___ Yes
   *(If **yes**, please complete the requested information below).*

   - **Name of Agency #1**: _____
     Dates of Attendance: _____
   - **Name of Agency #2:** _____
     Dates of Attendance: _____

2. **The Applicant has held a *Job in the Community*:** ___No ___ Yes

   *(If **yes**, please complete the requested information below).*

   - **Name of Business #1**: _____
     Dates of Employment: _____
     Type of Work/Duties Performed: _____
   - **Name of Business #2**: _____
     Dates of Employment: _____
     Type of Work/Duties Performed: _____
   - **Name of Business #3**: _____
     Dates of Employment: _____
     Type of Work/Duties Performed: _____

3. **The Applicant can *Write:*** ___No ___ Yes
   *(If **yes**, please describe their writing skills, i.e., how well can they write?):*_____
   _____

4. **The Applicant can *Read:*** ___No ___ Yes
   *(If **yes**, please describe their reading skills, i.e., how well can they read?)* _____
   _____

VI. MEDICAL INFORMATION:

A. Completion of the Medical Information:

1. The Applicant or the Applicant's Guardian, Parents or Physician should complete the medical information on this application. All information is strictly confidential and will not be used for any

purpose other than to guide Rainbow Omega, Inc. (ROI), in determining the appropriate level of care for the applicant and if applicable, assist in providing the care for the applicant.

2. The information will not be released to any other facility, agency, or individual without the expressed written consent of the Applicant, *(if legally allowed to do so)*, or the Applicant's Guardian, Parent, or Responsible Relative of an Adjudicated Applicant, or the Legal Agent holding the Power of Attorney for the Applicant.

B. **Required Immunizations:**

1. **Measles:** Applicant had the Measles or was vaccinated with the Live Measles Vaccine since 1968: ___ No___ Yes

2. **Mumps:** Applicant had the Mumps or was vaccinated with the Live Mumps Vaccine after 12 Months of Age: ___ No ___Yes

3. **Rubella:** Applicant had Rubella or was vaccinated after 18 Months of Age: ___No___ Yes

4. **Tuberculosis:** Please list the date of the Applicant's last Negative Chest X-ray or Tine Test: **Date:** _____

5. **Tetanus & Diphtheria:** Applicant was first vaccinated with a series of 3 Doses (*2nd Dose was 4-8 Weeks after the 1st Dose; 3rd Dose was 6-12 Months after the 2nd Dose*):___ No ___Yes

6. **Polio:** Applicant had the Series of Trivalent Oral Polio (OPV) Vaccine at 2, 4, & 18 Months of Age or the Applicant took 4 Doses of Inactive Polio Vaccine (IPV), continued IPV every 5 Years, until 18 Years of Age: ___ No ___ Yes

7. **Flu:** Applicant has received the Flu Vaccine: ___ No___ Yes
*(If **yes**, please list the date of the last vaccine)*. **Date:** _____

8. **Pneumococcal:** Applicant has received the Pneumococcal Vaccine. ___ No___ Yes
*(If **yes**, please list the date of the last vaccine).* **Date:** _____
9. **Hepatitis B:** Applicant received 3 Doses of the Hepatitis B Vaccine:___ No___ Yes
(*If **yes**, please list the date of the last vaccine).* **Date**: _____

10. **Covid-19:** Applicant has received the Covid-19 Vaccinations x 2: ___No ___ Yes
*(If **yes**, please list the date of the last vaccine and type. i.e., Pfizer, Johnson &Johnson, etc.).*
Date/s: _____ **Type:** _____

11. **Covid-19 Boosters:** Applicant has received the Covid-19 Booster Vaccinations: ___ No ___ Yes
(If yes, please list the date of the last booster and type).
Date/s: _____ **Type:** _____

C. **Personal Characteristics of Applicant:** **Gender:** _____**Height:** _____**Weight:**_____

D. **Applicant's Blood Type:** *(If known)*_____

E. **Allergies:**

1. **Medication Allergies:** *(i.e., penicillin, sulfa, codeine, etc.)*_____
_____

2. **Food Allergies:** _____

_____

3. **Other Allergies:** (*Please list other allergies if applicable):*_____

_____

(i.e., allergies to pollens, insect bites, skin contact, substances

F. **Allergy Medications/Injections:** (*If the applicant takes medications/injections to treat their allergies, please complete the following information for each medication)*:

1. _____

Medication/Injection	**Dosage**	**Frequency**	**Physician's Name**

2. _____

Medication/Injection	**Dosage**	**Frequency**	**Physician's Name**

3. _____

Medication/Injection	**Dosage**	**Frequency**	**Physician's Name**

G. Applicants Diet:

1. Is the Applicant on any Special Diet? (*i.e., low calorie, low fat, diabetic diet, etc.)*___No ___ Yes

a. If ***yes***, was the Special Diet recommended by his/her Physician? ___ No___ Yes

b. If ***yes***, please list the name of the Applicant's Special Diet Plan and describe the Special Diet as well as list the Food and Drink Items which are allowed on the plan:

_____

_____

_____

_____

H. **Applicant's Health History:** *(If you answer **yes**, to any of the following health conditions, please give details**.** You may attach extra pages if necessary).*

1. **Conditions**	**No**	**Yes**	**Details**
• Heart Trouble	___	___	_____
• Frequent Cold/Sinus Trouble	___	___	_____
• Headaches	___	___	_____
• Visual Problems	___	___	_____
• Glasses	___	___	_____
• Hearing Problems	____	___	_____
• Hearing Aid	___	___	_____
• Epilepsy	___	___	_____
• Tuberculosis	___	___	_____
• Kidney Disease	___	___	_____
• Obesity	___	___	_____
• Anemia	___	___	_____
• Stomach Trouble	___	___	_____
• Diabetes	___	___	_____
• Diarrhea	___	___	_____
• **F**ainting Spells	___	___	_____
• Menstrual Problems	___	___	_____
• Muscle Problems	___	___	_____
• Neurological Problems	___	___	_____
• High Blood Pressure	___	___	_____
• Other significant problems	___	___	_____

I. Medications:

1. **Name of Medications**	**Dosage**	**Frequency**	**Prescribing Physician**
#1_____	_____	_____	_____
#2_____	_____	_____	_____
#3_____	_____	_____	_____
#4_____	_____	_____	_____
#5_____	_____	_____	_____
#6_____	_____	_____	_____
#7_____	_____	_____	_____
#8_____	_____	_____	_____

2. **Can the Applicant Swallow Pills or do they need them Crushed?**
___No *(Needs pills crushed).* ___Yes *(Able to swallow whole pills).*

J. Physicians:

1. Primary Care Physician:

_____
First Name *MI* *Last Name*

Address: _____
Street *City* *State* *Zip*

Phone #: (_____) _____

2. **Dentist:** _____
First Name *MI* *Last Name*

Address: _____
Street *City* *State* *Zip*

Phone #: (_____) _____

3. **Ophthalmologist (*Vision*):** _____
First Name *MI* *Last Name*

Address: _____
Street *City* *State* *Zip*

Phone #: (_____) _____

4. **Other Physicians:** _____
First Name *MI* *Last Name*

Specialty: _____

Address: _____
Street *City* *State* *Zip*

Phone #: (_____) _____

a. **Does the applicant have a fear of going to a doctor or dental appointment beyond what is normal for most individuals?** ___NO ___ Yes **(***If yes, please describe what helps):*_____
_____
_____

b. **Does the applicant have a fear of getting Shots beyond what is normal for most individuals? ___ Yes ___ No (***If yes, please describe what helps):*_____
_____
_____

K. **Assistive Devices:**

1. Applicant ***has*** a **Prosthesis:** (*i.e., eye, leg, arm, etc.)*___No ___Yes
(*If **yes**, please give details)*: _____

2. Applicant ***needs*** a **Prosthesis:** ___ No ___ Yes
(*If **yes**, please give details)*:_____

3. Applicant ***uses*** a **Wheelchair:** ___ No ___ Yes
(*If **yes**, please give details)*:_____

4. Applicant ***needs*** a **Wheelchair:** ___ No ___ Yes

(*If **yes**, please give details)*:_____

5. Applicant ***uses*** a **Cane:** ___No ___ Yes
   (*If **yes**, please give details)*:_____
6. Applicant ***needs*** a **Cane:** ___No ___ Yes
   (*If **yes**, please give details)*:_____
7. Applicant ***uses*** a **Walker:** ___ No___ Yes
   (*If **yes**, please give details)*:_____
8. Applicant ***needs*** a **Walker:** ___ No ___ Yes
   (*If **yes**, please give details*): _____
9. Applicant ***wears*** **Dentures:** ___ No ___ Yes
   (*If **yes**, please check location)*: ___ Upper___ Lower___ Both
10. Applicant ***needs*** **Dentures:** ___ No ___ Yes
    (*If **yes**, please check location)*: ___ Upper___ Lower___ Both
11. Applicant ***wears*** **Hearing Aids:** ___ No ___ Yes
    (*If **yes**, please check location)*: ___ Right Ear___ Left Ear ___Both Ears
12. Applicant ***needs*** **Hearing Aids:** ___ No ___ Yes
    *(If **yes**, please check location)*: ___ Right Ear___ Left Ear ___Both Ears

J. Past Surgeries, Hospitalizations, Major Illnesses or Injuries:

1. Please list the Applicant's past Surgeries, Hospitalizations, Major Illnesses or Injuries and list the Dates of each Occurrence: *(i.e., Appendectomy, Spinal Meningitis, Broken Arm, etc.)*

- ➢ Incident: _____ Date: _____
- ➢ Incident: _____ Date: _____
- ➢ Incident: _____ Date: _____
- ➢ Incident: _____ Date: _____
- ➢ Incident: _____ Date: _____
- ➢ Incident: _____ Date: _____
- ➢ Incident: _____ Date: _____
- ➢ Incident: _____ Date: _____

K. Family Medical History:

1. Please check **Yes** or **No** to indicate whether any member of the Applicant's Family has ever had or received treatment for any of the following conditions: *(If **yes**, please Explain and Describe the Relationship of the Person to the Applicant)*.

Condition	Answer	Relationship to Applicant
• Heart Trouble:	___No ___Yes	_____
• Lung Trouble:	___No ___ Yes	_____
• High Blood Pressure:	___No ___Yes	_____
• Low Blood Pressure:	___No ___Yes	_____

- Stomach Trouble: ___No ___Yes _____
  (*i.e., ulcers*)
- Diabetes: ___No ___Yes_____
- Kidney Trouble: ___No ___Yes _____
- Cancer: ___No ___Yes _____
  (*If yes, type of cancer*): _____
- Thyroid Trouble: ___No ___Yes _____
- Glaucoma: ___No ___Yes _____
- Epilepsy: ___ No ___Yes_____
- Blood Disorders ___No ___Yes _____
  (i.e., "Free Bleeding")
- Hepatitis: ___ No ___Yes _____
- Nervous System *(i.e., Seizures, Strokes, etc.):* ___No ___Yes _____
- Other: _____

Additional Medical Factors:

1. List any other medical factors which would influence the care, health, and well-being of the Applicant:_____
_____

2. During the pregnancy or birth of the Applicant, were there any problems?___ No ___ Yes
(*If **yes**, please describe*): _____
_____

V. PSYCHOLOGICAL / BEHAVIORAL

A. Psychological Evaluation:

1. Applicant had a Psychological Evaluation: ____No ___ Yes
*(If **yes**, please list the date of the evaluation and the Applicant's Score on the (FSIQ) Full Scale IQ Test)*

a. **Date of Evaluation:** _____
b. **FSIQ:** _____
Reminder: Please send a copy of a Psychological Evaluation performed **after the age of 18, with this application.*

2. Does the Applicant receive care from a Therapist, Psychologist, or Psychiatrist?
___ No ___ Yes ***(If yes**, please describe the reason for the care and how long they have been receiving the care):*
_____
_____

3. Does the Applicant have a Psychiatric Diagnosis, other than his/her Intellectual and/or Developmental Disability Diagnosis? *(i.e., Depression, Anxiety, Schizophrenia, Insomnia, etc.)* ___No ___Yes
*(If **yes**, please list the Diagnosis and any symptoms the Applicant experiences due to the condition)*:_____
_____

4. Does the Applicant ever display any Physically Aggressive Behavior or have they displayed any in the past?

(i.e., hitting, spitting, kicking, biting, etc.) ___ No ___Yes *(If **yes**, please describe)*:_____
_____

5. Does the Applicant ever become Verbally Aggressive or have they in the past? *(i.e., cursing, threatening, screaming, profanity, etc.)* ___No ___Yes *(If **yes**, please* describe):_____
_____

6. Describe the Applicant's behaviors and display of emotions during situations which make him/her ***Sad***:
_____
_____

7. Describe the Applicant's behaviors and display of emotions during situations which make him/her ***Angry***:_____
_____

8. Describe what you believe is the most effective way of helping when the Applicant is ***Angry*** or ***Sad***:_____
_____

9. Describe what you believe is the least effective way of helping when the Applicant is ***Angry*** or ***Sad***:_____
_____

10. Does the Applicant have any great ***Fears*** or ***Phobias***? (i.e., heights, darkness, loud noises, spiders, etc.)___ No___ Yes (*If **yes**, please describe*): _____
_____

VII. FINANCIAL

A. Confidential Information regarding the Applicant's Financial Status:

1. Please be assured all information is strictly confidential and will only be shared with the Finance Department in order to help determine Financial Eligibility.

2. Does the Applicant receive any of the following Monthly Benefits? ___ No ___ Yes
(*If **yes**, please document the amount in the appropriate section*):

SSI: $_____ **SS/SSA: $**_____ **Other: $**_____
(*If **other**, please explain):*_____

3. Does the Applicant currently have a Bank Account in their name? ___ No ___Yes
*(If **yes**, is the balance greater than **$2,000)**?* ___ No ___Yes

4. Does the Applicant have any Assets or Funds in their name? ___ No ___ Yes
(i.e., property, land, cars, stocks, bonds, insurance policies, etc.).
*(If **yes**, please explain*): _____

5. Does the Applicant have a Trust Fund for their benefit?___ No ___ Yes

6. Does the Applicant have Medical Insurance Coverage?___ No ___ Yes
*(If **yes**, please check which coverage applies and list the Applicant's identification number)*

_____**Medicare** _____**Medicaid** _____**Other** *(Please list the name):*_____

Medicare # _____**Medicaid #**_____**Other #** _____

(*If **other,** please describe*): _____

7. If the Applicant's Parent or Guardian becomes deceased, who has been appointed to take over their role as the Responsible Party for the Applicant? *(Please complete the requested information for the appointed person below*):

   - **Name**:_____
     First *MI* *Last*
   - **Home Phone #** (_____) _____**Cell Phone #** (_____) _____
   - **Business or Alternate Phone #** (_____)_____
   - **Email Address:** _____
   - **Address:** _____
     Street *City* *State* *Zip*

8. Please describe any problems you have encountered while trying to find assistance or benefits for the Applicant? _____
   _____
   _____
   _____

9. Please share any additional information about the Applicant which you think would assist ROI in providing the best possible care for them:
   _____
   _____
   _____
   _____

I, _____ attest that the information contained in this Admission Application is to the best of my Knowledge and Belief, a Complete and True Statement of the Facts and Circumstances regarding the Applicant.

Signature/Mark of Applicant: _____ **Date:** _____

Name of Parent/Guardian/Family Member: _____ Date: _____
(Printed Name)

Signature of Parent/Guardian/Family Member: _____ Date: _____

Signature of Individual Completing the Application: _____ Date: _____
(If different from person listed above)