ELIM CHRISTIAN SERVICES
ADULT SERVICES SOCIAL HISORTY FORM

A. IDENTIFYING INFORMATION:

1. Name of Applicant: _____ Birthdate: _____

   Birthplace: _____
   City State County

   Sex: _____ Race: _____

2. How long has the applicant lived in Illinois? _____

   List names of cities and states of residence: _____

_

   _____

B. INFORMATION ABOUT APPLICANT'S FAMILY:

1. Father's Name: _____

   Contact: Street: _____

   City/State/Zip Code:_____

   Home Phone: _____ Cell Phone:_____

   Email address**:** _____

2. Mother's name: _____

   Contact: Street: _____

   City/State/Zip Code:_____

   Home Phone: _____ Cell Phone:_____

   Email address**:** _____

3. Applicant's brothers and sisters (include half and step brothers and sisters):

Sibling Names	Birth Date

C. APPLICANT'S PERSONAL HISTORY:

1. Check all of the following which describes the applicant:

	Alert		Generous		Loud		Selfish
	Angry		Happy		Mean		Sensitive
	Caring		Helpful		Moody		Shy
	Destructive		Hyperactive		Obedient		Slow learner
	Disrespectful		Impulsive		Peaceful		Smart
	Easily Distracted		In Own World		Personal Space		Tearful
	Energetic		Indifferent		Quiet		Threatening
	Fearful		Intimidating		Reflective		Withdrawn
	Forceful		Kind		Respectful		Other:
	Friendly		Lazy		Responsive		Other:

2. How does the applicant get along with each member of family and describe: _____

_____

_____

_____

3 Who does the applicant engage with regularly: parents, siblings, extended family, neighbors, community, church, school, service agency, peers, friends?

_____

_____

_____

4. What was the last school the applicant attended? _____

Check one: _____ Diploma _____ Certificate

5. Work History (include workshop attendance)

Company:	Job Title:
Job Description/Duties:	
□Independent □Supervised	Wages: □Minimum Wage □Subminimum Wage □Volunteer
Street Address: City:	Phone: ( ) State: Zip Code

Company:	Job Title:
Job Description/Duties:	
□Independent □Supervised	Wages: □Minimum Wage □Subminimum Wage □Volunteer
Street Address:	Phone: ( )
City: State: Zip Code	

Company:	Job Title:
Job Description/Duties:	
□Independent □Supervised	Wages: □Minimum Wage □Subminimum Wage □Volunteer
Street Address:	Phone: ( )
City: State: Zip Code	

6. List all therapies applicant has received? _____

_____

_____

7. Was applicant ever arrested? _____Yes _____No

If yes, give details: _____ _____

_____

_____

Are any charges pending? _____Yes _____No _____N/A

COMMENTS: _____

_____

_____

_____

_____

Name of person completing application: _____

Relationship to applicant: _____ Date Completed:_____

ELIM ADULT SERVICES
HEALTH AND MEDICATION HISTORY

Name:_____ _____ Date of Birth:_____
(Last) (First)

Parent/Guardian:_____

HEALTH HISTORY:

At what age was the applicant diagnosed as having a disability? _____ What was the diagnosis?

_____

Check all that the applicant has had:

☐Chicken pox [Year] ☐Ear infections [Year] ☐High fevers [Year]
☐Convulsions [Year] ☐Heart disease [Year] ☐Kidney problems [Year]
☐Other:

HOSPITALIZATIONS	
Reason for Hospitalization	Applicant's Age

Preferred Hospital: _____

Address: _____

Primary Care Physician: _____

Physician's Address: _____

Physician's Phone Number: _____

Current Medications _____

_____

_____

HEALTH STATUS:

List all allergies to medicine, food, etc.

_____

_____

Diet Restrictions:

_____

_____

Eating/Feeding Issues? Please explain:

_____

_____ _____

Most Recent Test Dates	
Hearing:	Last physical:
Vision:	Neurological evaluation:

Results: _____

_____

If the applicant has seizures, please describe how frequently and how he/she acts when having a seizure:

_____

_____

_____

NECESSARY EQUIPMENT:

☐Prothesis (crutch, cane)	☐Wheelchair	☐Glasses
☐Helmet	☐Brace	☐Other:_____

What medications is the applicant currently taking? _____

_____

_____

Name of any medical specialists

_____ _____

(Name) (Speciality)

_____ _____

(Name) (Speciality)

Additional information: _____

_____

_____

_____ _____

(Signature) (Date)

ELIM CHRISTIAN SERVICES
ADULT SERVICES INQUIRY FORM

1. PERSONAL CONTACT INFORMATION

Name of Applicant: _____

Sex: _____Female _____Male Birth Date: _____

Current Residence: _____Home _____Residential Placement

If applicable, name and address of Residential Agency:

_____

Name of current School or Day Program:_____

Month & year of high school graduation: _____

If attending Elim, name of program: _____

Religious Affiliation: ___ Reformed ___ Protestant ___ Catholic ___ Orthodox ___ Non-denominational
___ Jewish ___ Muslim ___ Other ___ None

Parent/Guardian Names: _____

Contact: Street: _____

City/State/Zip Code:_____

Home Phone: _____ Cell Phone/Name:_____

***Please include area codes & contact name.**

Email address**:** :_____

Guardian(s) Is the applicant his or her own guardian? _____Yes _____No

If no, name(s) of guardian(s) & relationship:_____

2. FUNDING

Does the applicant receive state funding? _____Yes _____No

If no, is the applicant on PUNS? _____Yes _____No

Are you interested in private pay? _____Yes _____No

PAS Agency/ISC Name: _____

HBS Agency/Service Facilitator Name: _____

3. MEDICAL INFORMATION

Primary Disability: _____

Secondary Disabilities: _____

Cognitive Level: _____Mild _____Moderate _____Severe _____Profound

Medical Issues: _____

_____

Does the applicant need to take medication during service hours? _____Yes _____No

Does the applicant require nursing service during service hours? _____Yes _____No

Allergies: _____Medication _____Food _____Seasonal _____Environmental
Specify Allergies: _____

_____

Diet Restrictions: _____

_____

Assistive and Communication Devices: _____

_____

4. FUNCTIONAL ABILITIES

A. Gross/Fine Motor

Mobility (check all that apply): _____independent _____physical guidance
_____crutches _____walker _____wheelchair manual power

Comments:_____

Use of both hands: _____functional _____ limited function _____no function

Comments:_____

B. Daily Living Skills

Check if help is required	Daily Living Skill	Describe/Explain Assistance Required
	Toileting	
	Dressing	
	Grooming	
	Eating	

C. Communication

Primary Language ___ English ___ Spanish ___ Other specify _____

Check all that apply:
_____verbal _____ communication device _____sign language

_____ photo/pictures _____facial expression/gestures/body movement

Comments: _____

D. Vocational
Has the applicant ever worked: _____Yes _____No

Where?_____

Describe Work Tasks and Job Tasks Performed: _____

_____

_____

E. Behavior

Check all that apply	Behavior	Describe/Explain Behavior
	Injures self	
	Causes pain/harm to others	
	Breaks/damages property	
	Interferes with others or activities	
	Unusual/repetitive habits	
	Offensive behavior	
	Withdrawn/inattentive	
	Uncooperative/stubborn	
	Other:	

Does the applicant have a behavior program: _____Yes _____No

Does the applicant take medications for behavior/mood: _____Yes _____No

Comments: _____

5. INTERESTS
What does the applicant enjoy doing at home during his or her free time? Where does the applicant enjoy going in the community? What are the applicant's special interests and passions?

_____

_____

_____

6. ADDITIONAL INSIGHTS

_____

_____

_____

6. SERVICES DESIRED

Service Desired	Program	Comments
	ACTS/Autism (staff ration 5 to 1)	
	Mild (DT 3 Orland-staff ration 10 to 1)	
	Moderate (DT 3-staff ration 8 to 1)	
	Severe/Profound (DT 1/Day Service-staff ratio 5 to 1)	
	Aging Disorders (Seniors-staff ration 5 to 1)	

7. TRANSPORTATION

Elim offers several transportation options. Families are invited to choose the option that best fits their applicant's needs and family budget. Check your preference.	
	Premier Door-to-Door van service (at an additional cost to me)
	A pick up/drop off point (at no additional cost to me)
	PACE vouchers
	Providing my own transportation

Name of person completing application: _____

Relationship to applicant: _____ Date Completed:_____

Send application and any available related materials to: Priority: _____ Initials: _____

Elim Christian Services
Donna Terry
15565 S. 70th Court
(708) 429-7493 ext. 605

Received: _____ Follow Up: _____

Tour: _____ Entered on Database/Filed: _____