APPLICATION FOR SERVICES
REFERRAL PROCEDURE

1. Inform Range Center, Inc. of your interest in admitting an individual with DD or related condition for services.

2. If you have not already done so, contact your County Public Health and Human Services Department and a Case Manager will be assigned to assist you.

3. Obtain application forms to be completed by guardian(s)/family and assigned Case Manager.

4. Please complete all forms—but if not applicable—identify as 'NA.' **Print or type.**

5. Submit all necessary admission information to Range Center, Inc. Supplementary items needed are listed on the Service Admission Checklist for Intensive Services.

6. If not already done, arrangements will be made for the applicant and Range Center, Inc. staff to meet and discuss possible placement and review of applicant needs.

7. No person will be discriminated against because of race, color, sex, national origin, age, or handicap.

Range Center, Inc.
1001 NW 8th Ave., PO Box 629
Chisholm, MN 55719
Phone: (218)-254-3347
Fax: (218)-254-7343
www.rangecenter.com

Personal Information

DATE _____

NAME _____
First Middle Last
Current Address _____ Phone _____
Street City State Zip
Birth Date_____ Place of Birth_____
MM/DD/YYYY City State County
Gender _____ Height _____ Weight _____ Hair_____ Eyes_____

Ambulatory? Yes [ ] No [ ] Identifying Marks _____

Special equipment _____

Primary Diagnosis(s) _____

Other Related Conditions _____

Social Security Number _____ PMI Number _____ County Case # _____

Medical Assistance Number_____ Other Insurance Types/Numbers_____

Language(s) _____Religious Preference _____ Guardianship _____

Previous Placement(s) _____ Date_____
_____ Date_____
Current /Education or Vocational Program _____

Father's Name _____ Birthplace _____
Address _____ Home Phone _____
_____ Work Phone _____
Mother's Name _____ Birthplace _____
Address _____ Home Phone _____
_____ Work Phone _____

Who has legal custody or guardianship? Mother [ ] Father [ ] Both [ ] Self [ ] Other [ ]
When other than parents or self, please specify:
Name _____Phone _____
Address _____
_____

Family Contact (or other) to notify in case of Emergency:
Name _____Phone _____
Address _____
_____

Medical Information

Current Physician _____ Phone _____
Address _____
_____ Date of last exam _____
Current Dentist _____ Phone _____
Address _____ Date of last exam _____
_____ Dentures Yes [ ] No [ ]

Current Eye Physician _____ Phone _____
Address _____ Date of last exam _____
_____ Glasses Yes [ ] No [ ]

ENT _____ Phone _____
Address _____ Date of last exam _____
_____ Hearing aids Yes [ ] No [ ]
Neurologist _____ Phone _____
Address _____ Date of last exam _____
_____ Comments _____
_____

Other Specialist _____ Phone _____
Address _____ Date of last exam _____
_____ Comments _____
_____

CURRENT MEDICATIONS			
Name	Dose	Frequency	Reason for Medication

Allergies

Medications Yes [ ] No [ ] List _____ Type of reaction _____
_____ _____
_____ _____

Food Yes [ ] No [ ] List _____ Type of reaction _____
_____ _____
_____ _____

Other Yes [ ] No [ ] List _____ Type of reaction _____
_____ _____
_____ _____

Physician ordered diet Yes [ ] No [ ] Date started _____ Type of diet _____
Reason_____

Physician ordered activity restriction or recommended precautions Yes [ ] No [ ]
List_____
_____

List all operations/injuries/illnesses which required hospitalizations.

DATE	REASON FOR HOSPITALIZATION	HOSPITAL LOCATION

Illnesses (List month and year if known)

Chicken Pox	German Measles	Pneumonia
Measles	Polio	Croup
Mumps	Whooping Cough	Tuberculosis
Scarlet Fever	Rheumatic Fever	Hepatitis A
Herpes		Hepatitis B

Is applicant prone to any of the following? (Please check if yes)

Constipation	Nose bleeds	Strep throat	Ear infections
Asthma	Diarrhea	Colds	Vaginal Infections
Weight gain	Weight loss	Urinary Tract Infections	

Does applicant have seizures? Yes [ ] No [ ] Age of onset _____ Date of last seizure _____

Average # of seizures per month _____ Type of seizure(s) _____

Immunizations

Enter month and year immunization was given

Type of Vaccine	1st	2nd	3rd	4th	Booster	Booster
DPT/TDaP						
Polio						
MMR						
Varicella (chickenpox)						
Pneumovac (last given)						

OTHER

Date of last Mantoux _____ Has applicant ever had a positive Mantoux Yes [ ] No [ ]
If yes, Date of last chest x-ray _____

Age menstruation began _____ Date of last period _____ Regular menstrual cycles. Yes [ ] No [ ]
If no, please comment _____

Has applicant been prescribed behavior controlling medication(s)? Yes [ ] No [ ] If yes, include the medication (s), start date(s), discontinued date(s) when applicable and explanation for use.

Medication	Start date	Discontinued date	Explanation

Financial Information

Financial Source(s) RSDI [ ] MA [ ] SSI [ ] Private [ ]

Savings Account Yes [ ] No [ ] Location _____

Checking Account Yes [ ] No [ ] Location _____
Health Insurance Yes [ ] No [ ] Company _____
Life Insurance Yes [ ] No [ ] Location _____
Burial Account Yes [ ] No [ ] Location _____
Real Estate Yes [ ] No [ ] Location _____Value_____
Personal Property (list) _____
_____

County of Financial Responsibility _____
Financial Worker _____ Phone _____
Address _____
Case Manager _____ Phone _____
Address _____

Educational History

School attended	Address	Grade	Dates attended	Year Graduated

Vocational History

Have you ever been employed? Yes [ ] No [ ] DT & H [ ] Sheltered [ ] Competitive [ ]

Please list name of program, vocational agency or employer:

Program/Agency	Address	Dates attended	Job duties	Reason for leaving

Name of Department of Vocational Rehabilitation Counselor (if any) _____
Address_____Phone #_____
Street City State Zip Code Area code/number

Skills Checklist

Please check items which best describe the individual applicant. Make comments when additional information is needed to explain.

EATING	**Consistently**	**Sometimes**	**Never**	**Comments**
Needs to be fed				
Throws or plays with food				
Eats finger foods				
Uses cup or glass				
Eats with spoon				
Eats with fork				
Uses knife for spreading				
Uses knife for cutting				
Eats slowly				
Eats rapidly				
Fussy eater				
Enjoys eating				
EATING continued	**Consistently**	**Sometimes**	**Never**	**Comments**

Shows good table manners				
Completely independent at meal time				
DRESSING				
Needs to be dressed completely				
Resists dressing				
Assists in dressing				
Attempts to dress self				
Puts on most clothing items				
Buttons clothes				
Ties Shoes				
Chooses own clothing				
Completely independent in dressing				
GROOMING	**Consistently**	**Sometimes**	**Never**	**Comments**
Needs complete assistance				
Washes hands				
Brushes teeth				
Combs or brushes hair				
Baths with supervision				
Bathes independently				
Shaves				
Shampoos hair				
Complete independence in grooming				
TOILETING	**Consistently**	**Sometimes**	**Never**	**Comments**
Is completely dependent				
Uses incontinent products				
Scheduled toileting				
Can indicate need				
Is incontinent during the day				
Is incontinent during the night				
Care for menstrual needs				
Is independent				
COMMUNICATION	**Consistently**	**Sometimes**	**Never**	**Comments**
Does not understand language				
Communicates with gestures only				
Communicates by signing				
Speaks single words				
Uses sentences				
Uses phrases				
Relates experiences				
Speech easily understood				
Speaks freely				
COMMUNICATION continued	**Consistently**	**Sometimes**	**Never**	**Comments**

Speaks incessantly				
Follows simple directions				
Answers questions				
Converses spontaneously				
Talks on telephone				
Prints				
Writes				
SOCIAL RELATIONS	**Consistently**	**Sometimes**	**Never**	**Comments**
Needs close supervision				
Accepts supervision				
Relates better to others than peers				
Avoids interaction				
Enjoys interaction				
Plays near, but not with others				
Disrupts group activities				
Makes close friends				
Has interest in opposite sex				
CHORES & ACTIVITIES	**Consistently**	**Sometimes**	**Never**	**Comments**
Helps with household tasks				
Helps with laundry				
Does responsible routine chores				
Helps with cooking				
Can be in neighborhood without supervision				
Makes purchases				
Uses public transportation				
Participates in community activities				
BEHAVIOR (check if answer is yes)	✓	**Comments**		
Hyperactive				
Aggressive				
Withdrawn				
Depressed				
Excessive habits				
Uses disruptive noises				
Self-stimulation (e.g. rocking, hand flapping)				
Self-injurious behavior				
OTHER Comments:				

This application was filled out by _____
Relationship/Title _____
Contact Information_____