

BROOKWOOD

1752 FM 1489
Brookshire, TX 77423
281-375-2169
www.brookwoodcommunity.org

APPLICATION FOR ADMISSIONS

Thank you for your interest in The Brookwood Community. Please complete and return the following items:

Application
Medical History
Release of Information
Application Fee of \$50.00
Recent family photo and individual photo

A thorough answer to all questions is essential. In addition to these forms, we need copies of the applicant's most recent educational, psychological, and psychiatric evaluations (if available) as well as any other information that would be helpful in determining whether Brookwood can meet this individual's needs.

The Admissions Committee conducts a thorough study of the information provided, determines the placement availability and suitability of each applicant, and notifies you whether or not to continue with the next step in the application process. If you have any questions, please do not hesitate to call our office.

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PLEASE ATTACH A RECENT INDIVIDUAL PHOTO, A FAMILY PHOTO, AND A \$50.00 APPLICATION FEE (NON-REFUNDABLE). APPLICATION WILL NOT BE REVIEWED UNLESS PHOTOS AND FEE ARE ATTACHED.

Check One:

- Residential / Work Program Brookwood at Gallery Furniture
Work Program Only (Day) Brookwood at The Woodlands

Date Placement Desired _____

Applicant's Full Name _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

() _____

Telephone _____ Social Security Number _____ Height _____ Weight _____ Sex _____

Mother's Name _____ Home Email Address _____ Home Telephone # _____ () _____

Home Address _____ City _____ State _____ Zip _____ Cell Phone # _____

Occupation / Name of Company _____ Bus. Email Address _____ Business Telephone # _____ () _____

Father's Name _____ Home Email Address _____ Home Telephone # _____ () _____

Home Address _____ City _____ State _____ Zip _____ Cell Phone # _____

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Occupation / Name of Company Bus. Email Address ()
Business Telephone #

Legal Guardian (Other Than Parent) Relationship

Home Address City State Zip

Occupation / Name of Company Email Address (Home and/or Business)

() () ()
Home Telephone # Business Telephone # Cell Phone #

Names and ages of applicant's siblings:

Please indicate the person or agency that referred you to Brookwood:

Have you attended a tour of Brookwood? YES NO

If yes, please check one of the following:

- Family Tour when: _____
- Regular Tour when: _____
- Personal Tour when: _____

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SCHOOLS OR PROGRAMS ATTENDED

CHECK ALL SITUATIONS IN WHICH THE APPLICANT HAS PARTICIPATED.

- | | |
|------------------------------------|------------------------------|
| _____ Day School | _____ Competitive Employment |
| _____ Sheltered Workshop | _____ State School |
| _____ Group / Family Care Home | _____ Private School |
| _____ Independent Living Situation | _____ Other, (Explain) |

PLEASE COMPLETE THE FOLLOWING INFORMATION ON EACH PROGRAM:
(Please use the back of this page if more space is needed)

1) _____
Name _____ Dates _____

Address _____ City _____ State _____ Zip _____

Type of Situation (Refer to list at top of page)

Reason for Leaving

Person to Contact for More Information

2) _____
Name _____ Dates _____

Address _____ City _____ State _____ Zip _____

Type of Situation (Refer to list at top of page)

Reason for Leaving

Person to Contact for More Information

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3)

Name Dates

Address City State Zip

Type of Situation (Refer to list on previous page.)

Reason for Leaving

Person to Contact for More Information

4)

Name Dates

Address City State Zip

Type of Situation (Refer to list on previous page.)

Reason for Leaving

Person to Contact for More Information

5)

Name Dates

Address City State Zip

Type of Situation (Refer to list on previous page.)

Reason for Leaving

Person to Contact for More Information

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PLEASE ANSWER THE FOLLOWING QUESTIONS:

- 1) Please describe applicant's general health, including special medical problems and/or physical disabilities:

- 2) Please describe applicant's communication abilities:

- 3) Please describe applicant's social/emotional state most of the time (for example: withdrawn, hyper-verbal, frustrated, sociable, even-tempered, etc.):

- 4) Does he/she prefer to be with peers, family, someone older, younger, or alone? Please explain:

- 5) Please describe applicant's self-help skills (What does someone need to do daily to help the applicant?).

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6) Please describe applicant's daily routines and leisure (free time) activities:

7) What do you see to be the applicant's functional disabilities?

8) What do you think applicant feels are his/her disabilities?

9) What are the applicant's specific aptitudes, interests, and/or strengths?

10) Has the applicant ever been involved with any of the following?

| | Yes | No |
|-------------------|-------|-------|
| Tobacco | _____ | _____ |
| Drug Abuse | _____ | _____ |
| Criminal Activity | _____ | _____ |
| Sexual Misconduct | _____ | _____ |

If yes, please explain:

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11) Please describe activity areas and/or situations that the applicant strongly dislikes:

12) Please describe activity areas and/or situations that the applicant enjoys:

12) Please describe your goals and expectations for the applicant and what you hope Brookwood can accomplish:

Please list three (3) individuals (different from those listed on page 4-5) who have worked with or known the applicant closely:

1) _____ () ()
Name Home Telephone Cell Phone #

Address City State Zip

Email

2) _____ () ()
Name Home Telephone Cell Phone #

Address City State Zip

Email

3) _____ () ()
Name Home Telephone Cell Phone #

Address City State Zip

Email

MEDICAL HISTORY

Name of applicant's primary physician:

_____ Telephone (____) _____

_____ Address _____ City _____ State _____ Zip _____

Please list any other specialists who have treated or are treating the applicant:

Is applicant on any regular medications? YES NO

If yes, please list below: (If more space is needed, use separate piece of paper and attach.)

| Medication | Dosage/Frequency | Prescribed By | Date Prescribed |
|------------|------------------|---------------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

ALLERGIES/RESTRICTIONS

Is applicant allergic to any medications? If yes, please list:

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Is applicant allergic to foods, pollens, insect bites, skin contacts, substances, etc? If yes, please describe reaction and what treatment is usually necessary:

Does applicant have any dietary restrictions? If so, please list:

If on any medication/injection for allergies, please give name of medication/injection, dosage and frequency:

Prescribed by: _____

HISTORY OF ILLNESS/HOSPITALIZATION/SURGERY

Has applicant had more than a brief illness during the past three year? YES NO

If yes, when? _____

Describe _____

Name of attending physician: _____

Has applicant ever been hospitalized? YES NO

If yes, when? _____

Describe: _____

Please list hospital and address: _____

City

State

Zip Code

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Has applicant had any surgery? YES NO

If yes, when? _____

Describe: _____

Please list hospital and address: _____

City State Zip Code

HEALTH HISTORY

If the applicant is prone to (or has had) problems with any of the following, please indicate YES or NO. If YES, explain in space provided. Also, list preferred treatment, if applicable. If extra space is needed, use separate piece of paper and attach.

- Cold/Sinus Trouble YES NO _____
- Headaches YES NO _____
- Eyes YES NO _____
- Glasses YES NO _____
- Ears YES NO _____
- Hearing YES NO _____
- Chest Infections YES NO _____
- Asthma YES NO _____
- Epilepsy/Seizures YES NO _____
- Tuberculosis YES NO _____
- Heart Trouble YES NO _____
- Kidney Disease YES NO _____
- Stomach Trouble YES NO _____
- Diabetes YES NO _____
- Diarrhea or Constipation YES NO _____
- Incontinent YES NO _____
- Fainting Spells YES NO _____
- Menstrual Problems YES NO _____
- Muscle Problems YES NO _____

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Neurological Problems YES NO _____
Emotional Problems YES NO _____
Psychological Problems YES NO _____
Psychiatric Problems YES NO _____

FAMILY PLANNING

Do you or someone else have guardianship of the applicant? YES NO

Are you signed up or on any federal waiver programs? YES NO

If yes, which one(s)? _____

IMPORTANT

If there is any further information you feel should be provided which is a factor and could influence the care, health, and well-being of this individual at Brookwood, please explain:

The information in the above medical history is correct to the best of my knowledge.

Signature of Parent/Guardian

Date

Signature of Applicant
(If Appropriate)

Date

Listed below are the fees associated with Residential and Day Program Citizens. Brookwood strives to provide financial assistance to those in need and to those who qualify.

| Work Program | | Residential Program | |
|---------------------|----------------|----------------------------|-----------------|
| Registration | \$500 | Registration | \$1,000 |
| Evaluation & Intake | \$1,000 | Evaluation & Intake | \$2,000 |
| Monthly Tuition | \$1095* | Monthly Tuition | \$4,600* |
| Monthly Bus Fee | \$130 | | |

***Extra care fees may apply – this will be determined at the Intake meeting**

Have you had a financial assessment done by a trained special needs financial planner? Y N

FINANCIAL (Banker, Financial Planner, Etc.)

| | | |
|---------|------------------|--------------|
| Name | () | () |
| | Home Telephone # | Cell Phone # |
| Address | City | State Zip |
| Email | | |

FINANCIAL (Banker, Financial Planner, Etc.)

| | | |
|---------|------------------|--------------|
| Name | () | () |
| | Home Telephone # | Cell Phone # |
| Address | City | State Zip |
| Email | | |

Will you be requesting Financial Assistance? Y N

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Please note that the application must be completed in full before it can be reviewed.

Please read and sign:

I affirm that the preceding information is a complete and true statement of all the facts and circumstances relative to this client's application for enrollment in The Brookwood Community.

We, the undersigned, do give our permission for Brookwood to contact any and all of the references, programs, schools, and professionals listed on this application.

I also authorize anyone who has any information on this client to release said information they hold on him/her to The Brookwood Community.

Copies of this release may be used to obtain information from anyone listed on application for acceptance into The Brookwood Community.

Signature of Parent/Guardian

Date

Signature of Applicant
(If Appropriate)

Date

Signature of person filling out application if other than
parent or guardian, and relationship to applicant.

Date

PHOTOGRAPH/ IMAGE CONSENT

The Brookwood Community would like your permission to use images/photos that may include your applicant.

I hereby grant permission to the Brookwood Community to photograph and video me, and otherwise capture my image, and to make recordings of my voice. I further grant to the Brookwood Community the right to reproduce, use, exhibit, display, broadcast and distribute these images and recordings in any media now known or later developed for promoting, publicizing or explaining the Brookwood Community and its activities and for administrative, educational or research purposes. Photographs, video images and voice recordings are the property of the Brookwood Community.

Signature of Parent/Guardian

Date

Signature of Applicant

Date

**THE BROOKWOOD COMMUNITY CONSIDERS ALL APPLICATNS
REGARDLESS OF SEX, RACE, RELIGION, OR ETHNIC ORIGIN.**

MEDICAL TREATMENT CONSENT

During Volunteer Days at Brookwood, we need the following consent signed in case a medical emergency should arise and your Applicant need immediate medical care or emergency transport to a hospital.

The Brookwood Community staff has my consent to obtain medical assistance and treatment for both routine and emergency care for:

Name of Applicant (please print)

Treatment includes but is not limited to the following:

- Ambulance transport to Hospital or Emergency Care facility
- Hospital admission for in-patient care
- Administering of prescribed medications
- X-Rays
- Lab Work

This authorization is valid throughout application process and Volunteer Days worked in The Brookwood Community.

Signature: _____ Date: _____

Relationship: _____