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.
APPLICATION FOR ADMISSIONS

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

__________________________________________

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<thead>
<tr>
<th>Applicant’s Full Name</th>
<th>Date of Birth</th>
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<tr>
<th>Occupation / Name of Company</th>
<th>Bus. Email Address</th>
<th>Business Telephone #</th>
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APPLICATION FOR ADMISSIONS

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:______________
SCHOOLS OR PROGRAMS ATTENDED

CHECK ALL SITUATIONS IN WHICH THE APPLICANT HAS PARTICIPATED.

_____ Day School

_____ Sheltered Workshop

_____ Group / Family Care Home

_____ Independent Living Situation

_____ Competitive Employment

_____ State School

_____ Private School

_____ 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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<td></td>
<td>Person to Contact for More Information</td>
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</table>
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?).
   _____________________________________________________________
   _____________________________________________________________
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?

<table>
<thead>
<tr>
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<th>Yes</th>
<th>No</th>
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<tr>
<td>Tobacco</td>
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<tr>
<td>Drug Abuse</td>
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<tr>
<td>Criminal Activity</td>
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<tr>
<td>Sexual Misconduct</td>
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</table>

*If yes, please explain:*

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

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

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:

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<tr>
<td>Email</td>
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</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage/Frequency</th>
<th>Prescribed By</th>
<th>Date Prescribed</th>
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ALLERGIES/RESTRICTIONS

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

________________________________________________________________________

________________________________________________________________________
APPLICATION FOR ADMISSIONS

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
APPLICATION FOR ADMISSIONS

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 ____________________________
APPLICATION FOR ADMISSIONS

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.

<table>
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<tr>
<th>Work Program</th>
<th>Residential Program</th>
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<tbody>
<tr>
<td>Registration</td>
<td>$500</td>
</tr>
<tr>
<td>Evaluation &amp; Intake</td>
<td>$1,000</td>
</tr>
<tr>
<td>Monthly Tuition</td>
<td>$1095*</td>
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<tr>
<td>Monthly Bus Fee</td>
<td>$130</td>
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<tr>
<td>Registration</td>
<td>$1,000</td>
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<tr>
<td>Evaluation &amp; Intake</td>
<td>$2,000</td>
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<tr>
<td>Monthly Tuition</td>
<td>$4,600*</td>
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</table>

*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.)

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Email

Will you be requesting Financial Assistance?  Y ☐  N ☐
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 __________________________ Date __________
(If Appropriate)

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 APPLICATIONS 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: ________________________