APPLICATION & ADMISSION PROCEDURES

EMAIL APPLICATION TO:

Lowell Bartels - bartelslowell@gmail.com

APPLICATION

1. Fill out this form and email it to **bartleslowell@gmail.com**.

2. Complete the following forms:
    a. Application form
    b. Sign "Release of Information" form
    c. Sign "Medical and Extended Care" agreement
    d. Sign the waver
    e. Contact Opportunity Resources to get placed on state list

3. A complete medical history is to be included with the application along with psychological evaluations from school and/or other sources, and vocational reports. The Screening Committee may request that an applicant have a psychological evaluation and/or a vocational assessment if these are not available or have become outdated.

4. Include recent color photograph of applicant. (An inexpensive snapshot is fine)

5. Return application to Farm in the Dell along with NON-REFUNDABLE $35.00 (thirty-five dollars) application fee for each application form submitted.

6. The application will be reviewed by the Executive Director to determine the compatibility for placement at the Farm in the Dell. The applicant and parent or guardian will be notified of the decision.

ADMISSION

1. If the Screening Committee determines that the applicant is a candidate for placement and an opening exists, an interview and introductory weekend will be scheduled. If no openings are available, the applicant will be placed on the waiting list and will be notified of an interview when an opening occurs.

2. Following the interview and introductory tour, the Executive Director will assess the applicant's compatibility and extend an invitation for a two (2) week compatibility period.

3. If the applicant is accepted for the two-week period, arrangements will be made for the date of arrival and a list of things the applicant will need to bring with them. The parents/guardians will be contacted for permission to extend the two-week period if necessary.

4. The following requirements must be met before the applicant moves to Farm in the Dell:
   a. Physical and dental examinations (within six months)
   b. A satisfactory method of payment is to be established. The monthly cost of care as established by the Board of Directors for Farm in the Dell is $4,000.00 per month.
   c. Any requirements concerning medication, special treatment or diet, etc. must be in writing (with a physician's note if possible) and medication should accompany the candidate.

5. Upon arrival, the applicant is received for a six (6) MONTH period to determine compatibility. At the end of this period, a written staff evaluation is shared with the applicant and parent or guardian. At this time, a determination of initial acceptance of the individual is made. Following an extended period of ninety (90) days, the final determination is made and shared with the applicant and parent or guardian.

PURPOSE OF Farm in the Dell

1 John 4:7-12 reads, "Beloved, let us love one another, for love is from God; and everyone who loves is born of God and knows God. The one who does not love does not know God, for God is love. By this the love of God was manifested in us, that God has sent His only begotten Son into the world so that we might live through Him. In this is love, not that we loved God, but that He loved us and sent His Son to be the propitiation for our sins. Beloved, if God so loved us, we also ought to love one another. No one has beheld God at any time; if we love one another, God abides in us, and His love is perfected in us." (NASB)

The purpose of Farm in the Dell Homes and Services for the Developmentally Disabled, Inc. relates these truths to the specific responsibilities of the Corporation. It is...

"To express God's love for people with developmental disabilities by meeting their spiritual, emotional, physical, social and intellectual needs through a group home and related services."

The Farm in the Dell Home is not simply a training or pass through program, but rather a place a person can make a permanent home. The program offers a Christian living and learning experience in a farm setting. Residents participate in the daily activities and maintenance of the garden, animals and home. An on-site, community based work activities program provides vocational training and community service. Regular participation in local churches and daily devotions and prayer support the spiritual and social needs of the residents.

STATEMENT OF FAITH

We believe the Bible to be the inspired, the only infallible, authoritative Word of God. We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory.

We believe that he Gospel is for everyone and that we are commanded by God to share that Gospel with every living soul. We believe that this mission is carried out through the spoken word and through the living example of Christ’s indwelling presence in acts of love and compassion

APPLICATION FOR ADMISSION

Farm in the Dell, International
for the Developmentally Disabled
1208 Poplar
Helena, MT 59601

Please note: The following forms ask for information that is vitally important, particularly if an applicant is selected for placement. We ask that you prayerfully consider all of the questions and answer them truthfully. Any falsification of information will be sufficient cause for disqualification or dismissal.

APPLICANT_____DATE:_____

Address: _____

_____ Telephone:(___)_____

Social Security Number: _____-_____-_____

Date of Birth:_____

Male [ ] Female [ ] Place of birth:_____

Does applicant take any medications? [ ] Yes [ ] No (Details on pg.13)

Is applicant's primary handicap mental retardation? [ ] Yes [ ] No

Explain:_____

Does the applicant have any secondary disabilities? [ ] Yes [ ] No

Explain:_____

Religious Affiliation: _____

REFERRAL SOURCE: [ ] Organization [ ]School [ ]Physician [ ] Other

Name :_____

Address:_____

_____ Telephone:(___)_____

Reason for referral (if referral is from someone other than parent/guardian):

_____

IN EMERGENCY CALL: Name_____ **Telephone: (___)**_____

Relationship: _____

FAMILY OF APPLICANT:

Father's Name: _____

Address: _____ Telephone:(___)_____

Employer: _____ Business phone: (___)_____

Mother's Name: _____

Address:_____

_____ Telephone:(___)_____

Employer: _____ Business phone: (___)_____

Legal Guardian's Name: _____

Address:_____

_____ Telephone:(___)_____

Employer: _____ Business phone: (___)_____

Relationship:_____

Give name, age and address of brothers and/or sisters of applicant:

Name	Age	Address	Telephone

PHYSICAL DESCRIPTION:

Present height _____ Height one year ago_____

Present weight _____ Weight one year ago _____

Difficulty with vision: Yes [ ] No [ ] If yes describe:_____

_____

Difficulty with hearing: Yes [ ] No [ ] If yes describe:_____

_____

COORDINATION: (Check one)

Gross motor coordination	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Fine motor coordination.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Walks independently	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Walks up & down stairs	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Runs	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Rides bicycle	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

(If applicable)
Physical limitations: _____

_____

Comments: _____

_____

COMMUNICATION:

Speech:	[ ] Verbal	[ ] Non-verbal	[ ] Gestures	[ ] Sign language [ ] Other
Speech can be understood	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Communicates basic needs	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Word usage	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Intelligible	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Phrase usage	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Speaks in sentences	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

Comprehension:

Understanding.	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Follows basic directions	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Answers basic questions.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

SELF CARE:

Eating:

Requires supervision	[ ] Yes	[ ] No (Describe below)		
Eating disorders	[ ] Yes	[ ] No (Describe below)		
Feeds self	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Eats family style	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses fork	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses spoon	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Knife to cut	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

Dressing:

Dresses self	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Cares for clothes	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Selects clothes	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Changes clothes as needed	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

Personal:

Brushes teeth	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Flosses teeth	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses deodorant	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Shampoos hair	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Grooms hair	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Shaves	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Washes hands	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Takes bath/shower alone	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses toilet paper	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Menstrual care	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

HOUSEKEEPING:

Cleans room	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Makes bed	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Washes clothes	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Puts clothes away	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Washes dishes	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Dries dishes	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Sets & clears the table	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Vacuums carpets	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Dusts furniture, etc.	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Sweeps floors	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Wet mops the floor.	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Empties the trash	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Shovels snow	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Irons clothing	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Mends clothing	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Mows lawn	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

PROBLEM BEHAVIORS: (Check any that apply)

[ ] Argues	[ ] Swears	[ ] Bosses others	[ ] Up at night
[ ] Self-injurious behavior	[ ] Steals	[ ] Runs away	
[ ] Non-compliance	[ ] Lies	[ ] Wets bed	

[ ] Physically aggressive (toward others)
[ ] Physically aggressive (toward property)
[ ] Inappropriate sexual behavior

Please describe the individual's most significant inappropriate behaviors: _

_____

_____

_____

MONEY MANAGEMENT:

Understands money	[ ] Yes [ ] No			
Gives next dollar over amount	[ ] Yes [ ] No			
Pays exact amounts	[ ] Yes [ ] No			
Uses checkbook.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Buys personal items.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Shops in store	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Withdraws & deposits money in bank ..	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

SOCIALIZATION AND COMMUNITY SKILLS:

Maintains appropriate social distance	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Offers assistance to others.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Shows consideration of others feelings.	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Gets along well with peers of same sex	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Gets along well with peers of opposite sex	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Gets along well with adults of same sex.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Gets along well with adults of opposite sex.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Accepts constructive criticism.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Is willing to help when asked.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Assumes responsibility when asked	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Relates well to authority figures.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Participates in group activities.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Behaves appropriately in public.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Moves about freely in familiar surroundings	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses public transportation	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Makes friends easily	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

INDEPENDENCE:

Gives knowledge of self (name, address & tele.).....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Operates home appliances safely.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses telephone	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Recognizes need for medical services	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Seeks medical help in an emergency	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Recognizes vital signs in another	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Takes own medications.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Sets alarm clock for getting up on time.....	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Goes to bed at a required time .....[ ] Excellent [ ] Good [ ] Fair [ ] Poor

INDEPENDENCE: (cont.)

Keeps perishable food for safe lengths	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Fixes breakfast & lunch for self	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Fixes at least two different evening meals	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Safely uses a sharp kitchen knife	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Does home repair and maintenance	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses electric equipment (drill, food mixer, saw etc)	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses sewing machine	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses washer/dryer	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Has knowledge of fire safety	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Leaves building at the sound of fire alarm	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

ACTIVITIES & INTERESTS:

Initiates hobbies during "free time"	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Participates in leisure activities	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Enjoys going on outings such as picnics etc	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Has shown responsibility with owning a pet	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Feels comfortable around small animals (cats, dogs)	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Feels comfortable around large animals (cows, sheep)	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Likes the out-of-doors	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Enjoys gardening	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Has worked in a garden	[ ] Yes	[ ] No		
Knows how to swim	[ ] Yes	[ ] No		

Comments: _____

_____

Applicant's indoor interests are: _____

_____

Applicant's outdoor interests are: _____

_____

ACADEMIC:

Tells time to the minute	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Tells time to 15 minutes	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Adds & subtracts basic math problems	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Uses a calculator	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Can read	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Can write	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Can communicate a message on the phone	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Can write a message taken on the phone	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Can apply number concepts up to ten	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor
Can apply number concepts beyond ten	[ ] Excellent	[ ] Good	[ ] Fair	[ ] Poor

Comments: _____

_____

MEDICAL CARE:

1. Physician's name, address: _____

_____ Telephone:(___) _____

Date of last physical: _____ Visit: _____

Results: _____

2. Dentist's name, address: _____

_____ Telephone:(___) _____

Date of last exam: _____

Results: _____

Does applicant currently require any dental work? [ ] Yes [ ] No

Explain: _____

3. Eye doctor's name, address: _____

_____ Telephone:(___) _____

Date of last exam: _____

Results: _____

Wears glasses? ...[ ] Yes.....[ ] No.....All the time? .....[ ] Yes .....[ ] No

Wears contacts? ..[ ] Yes.....[ ] No.....Takes care of them? .....[ ] Yes .....[ ] No

If Yes, reason for wearing glasses and/or lenses: _____

Sight with glasses/lenses.....[ ] Excellent [ ] Good [ ] Fair [ ] Poor

4. Hearing doctor's name, address: _____

_____ Telephone:(___) _____

Date of last exam: _____

Results: _____

Does applicant wear hearing aids?.....[ ] Yes .....[ ] No

Hearing with aids?.....[ ] Excellent [ ] Good [ ] Fair [ ] Poor

INSURANCE:

Hospitalization Insurance .....[ ] Yes [ ] No

If Yes, name of company: _____

Policy No. _____

Medical/Health Insurance?.....[ ] Yes [ ] No

If Yes, name of company: _____

Policy No. _____

Will insurance cover dental and/or eye needs? [ ] Yes [ ] No

Additional medical information: _____

_____

_____

MEDICAL HISTORY:

PART 1
Present health condition.....[ ] Excellent [ ] Good [ ] Fair [ ] Poor

For the following please indicate with a **P** for a past condition, indicate with a **C** for a continuing condition, and an **N** for never.

Eyes:
Eye disease __ Eye injury __ Impaired sight __

Ears:
Ear disease __ Ear injury __ Impaired hearing __

Nose/throat:
Sinuses __ Throat __ Nose Trouble __ Other: __

Fainting spells __ Convulsions __ Loss of consciousness __

Paralysis __ Frequent or severe headaches __ Dizziness __

Depression or anxiety __ Hallucinations __

Enlarged glands __ Goiter or enlarged thyroid __

Skin disease (name) _____

Chronic or frequent cough __ Chest pain or angina pectoris __

Spitting up of blood __ Night sweats __

Shortness of breath __ Palpitation or fluttering heart __

Varicose veins __ Swelling of hands, feet or ankles __

Extreme tiredness or weakness _____ Explain: _____

_____

Kidney disease or stones __ Bladder disease __ Bladder infection __

Albumin-sugar-pus-etc. in urine __ Difficulty in urinating __ Incontinence __

Stomach trouble or ulcers __ Indigestion __ Liver or gallbladder disease __

Colitis or other bowel disease (name): _____

Appendicitis __

Hemorrhoids or rectal bleeding __ Constipation or diarrhea __.

O t h e r

_____

_____

_____

Comments or Concerns

PART 2

Medications:

Does the applicant take any prescribed drugs? [ ] Yes [ ] No

Please name them and give amounts and directions for taking them:

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Medication: _____ Directions: _____

Does the applicant take any other medications or vitamins regularly or frequently? [ ] Yes [ ] No

If Yes, please name them: _____

_____

Known allergic reactions to medications? [ ] Yes [ ] No

If Yes, please name them: _____

_____

Does the applicant administer own medication? [ ] Yes [ ] No

PART 3

Cause of Developmental Disability if known: _____

_____

PART 4

Injuries: Give type and date of injury:

Broken bones? .....[ ] Yes [ ] No _____

Sprain or dislocation? .....[ ] Yes [ ] No _____

Lacerations (extensive)? .....[ ] Yes [ ] No _____

Concussions or head injuries? ...[ ] Yes [ ] No _____

Lost consciousness? .....[ ] Yes [ ] No Explain_____

Please explain other injuries: _____

PART 5

Examinations & tests:

Any x-rays in last five years? [ ] Yes [ ] No

Physician's name, address: _____

_____ Telephone:(___)_____

Results: _____

Surgery & treatments: Give details:

Tonsillectomy [ ] Yes [ ] No _____

Appendectomy [ ] Yes [ ] No _____

Hernia [ ] Yes [ ] No _____

Transfusion (blood or plasma) [ ] Yes [ ] No If Yes explain: _____

Blood type (if known) ___ Hemophiliac [ ] Yes [ ] No

Any other operations? [ ] Yes [ ] No If Yes explain:_____

_____

Has the applicant ever been advised to have any surgical operation which has not been done?

[ ] Yes [ ] No If Yes explain: _____

PART 6

Psychological Information:

Has the applicant ever had a psychological evaluation? [ ] Yes [ ] No

If Yes, date of evaluation:_____(Mo/yr) Name of evaluator: _____

Other doctors (Neurologists, Pediatricians, Allergy Specialists or Chiropractors, etc.)

Please give dates & details:

_____

PART 7

Personal Medical History (Please check all that apply)

			Dates and/or comments:
Epilepsy (see also Part 8)	[ ] Yes	[ ] No	_____
Measles or German Measles.	[ ] Yes	[ ] No	_____
Chicken pox or Mumps.	[ ] Yes	[ ] No	_____
Whooping cough	[ ] Yes	[ ] No	_____
Scarlet fever or Scarlatina.	[ ] Yes	[ ] No	_____
Pneumonia or Pleurisy	[ ] Yes	[ ] No	_____
Diphtheria or Smallpox	[ ] Yes	[ ] No	_____
Influenza	[ ] Yes	[ ] No	_____

Rheumatic fever or heart disease .....[ ] Yes [ ] No _____

Personal Medical History (cont.) (Please check all that apply)

Heart murmur.	[ ] Yes	[ ] No	_____
Arthritis or Rheumatism.	[ ] Yes	[ ] No	_____
Any bone or joint disease	[ ] Yes	[ ] No	_____
Neuritises or neuralgia.	[ ] Yes	[ ] No	_____
Bursitis, sciatica or lumbago	[ ] Yes	[ ] No	_____
Polio or meningitis	[ ] Yes	[ ] No	_____
Back or foot problems	[ ] Yes	[ ] No	_____
Bright's disease or kidney infection	[ ] Yes	[ ] No	_____
Gonorrhea or Syphilis.	[ ] Yes	[ ] No	_____
Hepatitis	[ ] Yes	[ ] No	_____
Anemia or jaundice	[ ] Yes	[ ] No	_____
Migraine headaches	[ ] Yes	[ ] No	_____
Tuberculosis	[ ] Yes	[ ] No	_____
Diabetes or Cancer.	[ ] Yes	[ ] No	_____
High or low blood pressure	[ ] Yes	[ ] No	_____
Food, chemical or drug poison	[ ] Yes	[ ] No	_____
Hay fever or Asthma.	[ ] Yes	[ ] No	_____
Hives or Eczema	[ ] Yes	[ ] No	_____
Frequent colds or sore throat.	[ ] Yes	[ ] No	_____
Bronchitis.	[ ] Yes	[ ] No	_____
Mononucleosis	[ ] Yes	[ ] No	_____
Hernia	[ ] Yes	[ ] No	_____
Frequent infections or boils	[ ] Yes	[ ] No	_____
HIV Positive or Anti-Immune Deficiency (AIDS)	[ ] Yes	[ ] No	_____

Any other diseases? [ ] Yes [ ] No If Yes, please explain: _____

_____

PART 8

Seizures:

Does the applicant have any history of seizures? [ ] Yes [ ] No

If Yes, please check the type:

[ ] Generalized Clonic Tonic (also called Grand Mal)
[ ] Absence (also called Petit Mal)
[ ] Simple Partial (also called Jacksonian)
[ ] Complex Partial (also called Psychomotor or Temporal Lobe)
[ ] Atonic Seizures (also called Drop Attacks)
[ ] Myoclonic Seizures
[ ] Infantile Spasms

When was the last noted seizure activity? _____ Mo/yr

Check frequency of seizures: [ ] Daily .....[ ] Weekly [ ] Bi-weekly [ ] Monthly [ ] Other

Comments: _____

_____

PART 9

Immunizations: (Please check all that apply)

			Dates:
Smallpox	[ ] Yes	[ ] No	_____
Typhoid	[ ] Yes	[ ] No	_____
Mantoux (TB).	[ ] Yes	[ ] No	_____
Diphtheria-Tetanus	[ ] Yes	[ ] No	_____
Polio or meningitis	[ ] Yes	[ ] No	_____
DPT.	[ ] Yes	[ ] No	_____
Polio Series	[ ] Yes	[ ] No	_____
Measles/Mumps/Rubella.	[ ] Yes	[ ] No	_____

PART 10

Allergies: (Please check all that apply)

			Reaction:
Penicillin	[ ] Yes	[ ] No	_____
Aspirin, Codeine or Morphine	[ ] Yes	[ ] No	_____
Mycins or other antibiotics.	[ ] Yes	[ ] No	_____
Merthiolate or Mercurochromes	[ ] Yes	[ ] No	_____
Tetanus Antitoxin or Serums	[ ] Yes	[ ] No	_____
Bee stings.	[ ] Yes	[ ] No	_____
Any other drug	[ ] Yes	[ ] No	_____
Any foods.	[ ] Yes	[ ] No	_____
Adhesive tape	[ ] Yes	[ ] No	_____
Nail polish or other cosmetics	[ ] Yes	[ ] No	_____
Others (name: _____)	[ ] Yes	[ ] No	_____

PART 11

Diet:

Is the applicant on a special diet? [ ] Yes [ ] No

If special diet, please give reason and state type & details of diet:

_____

_____

Is there anything about the applicants eating habits we should know about, please explain:

_____

_____

PART 12 (Women Only)

Menstrual History:

Age at onset __ Flow: Heavy [ ] Medium [ ] Light [ ]

Regular _____ Irregular _____
Cycle: ___ days (from start to start)

Usual duration: ____ days

Pain or cramps: .....[ ] Yes [ ] No
If Yes what is usually done? _____

Ever had a Pap Smear? .....[ ] Yes [ ] No If Yes, date: _____

Was it negative? .....[ ] Yes [ ] No

Does the applicant see to her own menstrual care? [ ] Yes [ ] No

Comments: _____

PART 13

Family History:

Father's health (if living):
[ ] Excellent [ ] Good [ ] Fair [ ] Poor
If deceased, cause: _____ Age of Death: _____

Mother's health (if living):
[ ] Excellent [ ] Good [ ] Fair [ ] Poor
If deceased, cause: _____ Age of Death: _____

Brother or sister's health (if living):
[ ] Excellent [ ] Good [ ] Fair [ ] Poor
If deceased, cause: _____ Age of Death: _____

Brother or sister's health (if living):
[ ] Excellent [ ] Good [ ] Fair [ ] Poor
If deceased, cause: _____ Age of Death:

Has any blood relative ever had:
(Please check all that apply) Who:

Epilepsy.	[ ] Yes	[ ] No	_____
Cancer	[ ] Yes	[ ] No	_____
Tuberculosis	[ ] Yes	[ ] No	_____
Diabetes	[ ] Yes	[ ] No	_____
Heart Trouble	[ ] Yes	[ ] No	_____
High Blood Pressure.	[ ] Yes	[ ] No	_____
Stroke	[ ] Yes	[ ] No	_____
Mental Illness.	[ ] Yes	[ ] No	_____
Suicide	[ ] Yes	[ ] No	_____
Arthritis	[ ] Yes	[ ] No	_____
Congenital Deformities.	[ ] Yes	[ ] No	_____
Back Trouble	[ ] Yes	[ ] No	_____
Foot Problems.	[ ] Yes	[ ] No	_____

Spasticity .....[ ] Yes [ ] No _____
Cerebral Palsy .....[ ] Yes [ ] No _____

*** * * * * * * * * * * * * * * CONFIDENTIALITY * * * * * * * * * * * * * * ***

Farm in the Dell, International Homes & Services for the Developmentally Disabled strictly adheres to the right of privacy for our residents and staff. Therefore, records for residents and staff files shall be maintained in a professional manner and with the utmost regard for confidentiality. The Executive Director is responsible for assuring that only appropriate persons have immediate access to these records. Specific information within the records may be made available to other professionals, agencies, and individuals who have been authorized to have access, or to review case information, either by law or with the signed consent of the individuals. Under no circumstances shall a staff member divulge without proper authorization any information relating to a resident or staff member to parties outside the organization, or to parties inside the organization not having training or supervision responsibility for that person. To do so will result in immediate disciplinary action which may include discharge from employment.

I HEREBY CERTIFY THAT THE INFORMATION PRESENTED ON THIS APPLICATION FORM IS TRUE, ACCURATE AND COMPLETE. ANY FALSIFICATION WILL BE SUFFICIENT CAUSE FOR DISQUALIFICATION OR DISMISSAL. REFERENCES AND PERSONAL INFORMATION WHICH BECOME A PART OF THIS RECORD WILL BE REGARDED AS CONFIDENTIAL.

_____	_____	_____
SIGNATURE	DATE	RELATIONSHIP TO APPLICANT

_____	_____
NOTARY PUBLIC	DATE

MEDICAL & EXTENDED CARE AGREEMENT

I/we the undersigned do hereby agree to be responsible for the payment of all medical expenses (in the event that the applicant is not covered under Medicaid and/or Medicare) while he/she is a resident with Farm in the Dell home.

_____ _____
Parent Date

_____ _____
Guardian Date

In the event of an emergency, I do hereby authorize the Director of Farm in the Dell, or another staff member of Farm in the Dell, to give consent for medical treatment for the applicant.

_____ _____
Parent Date

_____ _____
Guardian Date

Farm in the Dell, International Homes & Services
for the Developmentally Disabled
1208 Poplar
Helena, MT 59601

RELEASE OF INFORMATION

I, _____, give my consent to release any pertinent information regarding

_____ to Farm in the Dell Home.
Name of Applicant

_____ _____ _____
SIGNATURE DATE RELATIONSHIP TO APPLICANT

_____ _____
Applicant Signature DATE

EMAIL APPLICATION TO:
Lowell Bartels - bartelslowell@gmail.com