



Passage  
to a brighter  
future

TTY and ASCII Users: (800) 720-3840  
*Latham Centers is an equal opportunity provider and employer\**

**APPLICATION FOR ADMISSION**

Children's Services       Adult Services

**INDIVIDUAL INFORMATION**

Individual:	Date of Referral:
Date of Birth:	Social Security #:
Religion:	Place of Birth:
Nationality:	Race:
Citizenship:	
Name of person making referral:	
Title:	
Reason for Referral:	
Is a social service agency(ies) involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name:	
Address:	
Contact:	
Phone:	

Placement History (Please list all prior placements, including specialized day programs).

Does individual require any specialized equipment or accommodations?

Are there specific restrictions or needs that are important for Latham Centers to be aware of?

**FAMILY INFORMATION**

<b>Parent(s):</b>	
Mother:	Father:
Mother's Maiden Name:	
Address:	Address:
Phone:	Phone:
Fax:	Fax:
e-mail:	e-mail:
Date of Birth:	Date of Birth:
Place of Birth:	Place of Birth:
Nationality:	Nationality:
Race:	Race:
Primary Language:	Primary Language:
Home Language:	Home Language:
<b>Legal Guardian</b>	<b>Emergency Contact</b>
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
e-mail:	e-mail

**Adoptive/Step Parent (if applicable)**

Adoptive/Step Mother	Date of Birth	Place of Birth
Address	Nationality	Race
Phone	Fax	e-mail
Adoptive/Step Father	Date of Birth	Place of Birth
Address	Nationality	Race
Phone	Fax	Place of Birth

**Siblings:** Please list all siblings, date of birth, current address and indicate if half brother/sister and which parent.

Sibling	Date of Birth	Current Address	Half Brother/Sister	Which Parent

**Family History:** Below list the name, age, medical (history of cancer?), learning disorders/giftedness, mood disorders, postpartum depression, psychotic disorders, OCD/tics, degenerative diseases (Parkinson's, Alzheimers, etc.) education, and employment of each family member.

Name	Age	History

**Recent Challenges at School and Home for student:**

**Current Involvement:** Indicate if any of the following legal issues apply to the individual. If yes, specify.

		If Yes, Specify
DDS/Current ISP	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Guardianship	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rogers Petition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DCF Involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHINS	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arrests	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Probation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trusts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DMH	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**EDUCATION**

Elementary  Secondary  Post Secondary

IQ: \_\_\_\_\_ If student, does he/she have an IEP?  Yes  No

Highest Grade Completed? \_\_\_\_\_

School District: \_\_\_\_\_ Name of School/College \_\_\_\_\_

Contact Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

Did individual repeat any grades?  Yes  No, If yes which ones? \_\_\_\_\_

Special Ed?  Yes  No

Date Eligible for Special Ed (if known disability, date is generally at 3<sup>rd</sup> birthday) \_\_\_\_\_

**MEDICAL, SOCIAL and PSYCHIATRIC HISTORY**

**THE INFORMATION BELOW MUST BE COMPLETED FULLY FOR ADMISSION**

**Parents MUST provide Latham with all insurances including Medicaid numbers, Out-of-State Insurance, Dental Insurance, etc. Latham is NOT responsible for any co-pays.**

**Dental Insurance, if applicable:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

(Please send copy of front and back of all insurance cards. Actual insurance cards will be needed on date of intake)

Does individual wear glasses?  Yes  No

Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Hair color: \_\_\_\_\_

Eye color: \_\_\_\_\_ Identifying marks (scars): \_\_\_\_\_

**Allergies:**

Medications:	
Foods:	
Environmental:	
Other:	

**Current Medications:**

(Include over the counter medications)

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**Current Diagnoses: Include all Medical and Psychiatric**

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**WE ARE NOT ABLE TO ACCEPT ANY MEDICATIONS FROM HOME AS ALL OUR MEDICATIONS COME FROM THE PHARMACY USING THE MEDICATION ON TIME SYSTEM. OUR REGULATIONS REQUIRE PRESCRIPTIONS AND WRITTEN PHYSICIAN ORDERS FOR ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS (INCLUDING PRN'S AND OVER THE COUNTER MEDICATIONS (vitamins, fish oils, pain relievers, creams, other supplements, c-paps etc). IF AN INDIVIDUAL COMES WITHOUT THESE IN PLACE, THEY WILL NOT BE ABLE TO RECEIVE THEIR MEDICATIONS UNTIL THE PRESCRIPTIONS ARE ACQUIRED. (If you have any questions, please notify the Admissions Department or someone from our Nursing Department).**

<b>Physicians/Health Care Professionals:</b>	
<b>Physician (Primary)</b>	Last physical date and results:
	<b>(Physical must be within last 12months)</b>
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Physician (Psychiatric)</b>	Last apt. date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Dental</b>	Last appointment date and results:
Dentist Name:	<b>(Dental appointment must be within last 6 months)</b>
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Physician (Eye)</b>	Last appointment date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Physician (Other)</b>	Last appointment date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Physician (Other)</b>	Address:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**PAST MEDICAL HISTORY:**

**Communicable Diseases:**

Has individual ever had	Yes	No	Date
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rubella	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**Hospitalizations/Operations:**

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>	<u>Doctor</u>

**Please indicate past or present medical problems:**

**Psychiatric/Behavioral Problems**

Has individual ever had or currently have any of the following problems. For any 'yes' answers, please give current status/specifics on separate page and send that with this form.

<b>Problem</b>	<b>Yes</b>	<b>No</b>	<b>Problem</b>	<b>Yes</b>	<b>No</b>
Agitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicidal Thoughts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Phobias	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mood Swings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feeling of Worthlessness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rapid Cycling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Control	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nightmares	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Terrors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hoarding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self-Injurious Behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elopement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fire Setting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rumination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	PICA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Picking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin <input type="checkbox"/>	Rectal <input type="checkbox"/>	
Aggression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Verbal <input type="checkbox"/>	Physical <input type="checkbox"/>	

**Growth and Development:**

<b>Child</b>			
Describe strengths:			
Describe weaknesses:			
Describe how individual interacts with others in the family. With peers.			
Does the Individual exercise daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	For how Long:	
Does the individual Steal?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is a Behavior Plan in use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(If yes send a copy)			
What behavioral guidelines help the most?			
What are some of the minor aggressive actions that cannot be redirected?			
What is the most serious aggressive act?			
Where do most of the aggressions occur?			
Home <input type="checkbox"/>	School <input type="checkbox"/>	Bus <input type="checkbox"/>	In Public Place <input type="checkbox"/>
What coping mechanisms work for the individual?			
Is any Counseling received?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes what type	Family <input type="checkbox"/>	Individual <input type="checkbox"/>	Group <input type="checkbox"/>
Are sensor alarms used in the house?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there alarms installed on windows and doors?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, for how long?			
Reason installed			

Is a special seat belt used for transportation on a school bus or van?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type	

What level of supervision is needed in the community?			
Full Supervision <input type="checkbox"/>	Some Supervision <input type="checkbox"/>	Some Independence <input type="checkbox"/>	Full Independence <input type="checkbox"/>

Can individual carry money?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can individual use public transportation independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can individual spend time alone at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, How long?	
Does individual use telephone appropriately?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, How Long?	
Orders take-out food to be delivered when unsupervised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does individual have any vocational or work experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	
Does individual use a computer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe level of their ability	

**FILL THIS SECTION OUT IF INDIVIDUAL HAS PRADER-WILLI SYNDROME**

Date of PWS diagnosis:	
Diagnosis made by whom:	
What are the genetic findings (deletion, disomy, mylation defect)?	

Please provide copies of genetic testing to Latham.

What has been the course of medical treatment for PWS (include dates started):					
-growth hormone?					
-Thyroid hormone?					
-Estrogen/testosterone replacement?					
At what age did the child begin to over eat?					
Highest individual ever weighed				Weight today	
Has individual been given a goal weight?					
Is their Diet:	Structured <input type="checkbox"/>	Calories counted <input type="checkbox"/>	Eats what family eats <input type="checkbox"/>		
Describe how individual acts in public where food is available.					
Does the individual food seek?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes:	in the neighborhood <input type="checkbox"/>	Garbage <input type="checkbox"/>	School <input type="checkbox"/>	Work <input type="checkbox"/>	Home <input type="checkbox"/>

Does the individual food seek?	Limited <input type="checkbox"/>	Unlimited <input type="checkbox"/>	How many used daily?	
Does the individual drink water?	<input type="checkbox"/> Yes <input type="checkbox"/> No		How many glasses a day?	
How many calories consumed in a day?				
Are the cabinets/ refrigerators locked at home?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the family current on PWS research?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does a family member belong to a PWS support group or network?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

**\*Statement of nondiscrimination:**

**Latham Centers, Inc. (Latham) provides equal opportunity for all individuals served and employed.** Latham does not discriminate on the basis of race, color, ancestry, national origin, ethnic group identification, religion, marital or parental status, physical or mental disability, sex, sexual orientation, gender, gender identity or expression, genetic information, age, veteran status, or any other category protected under applicable law in treatment or employment at Latham, admission or access to Latham, or any other aspect of the programs and activities that Latham operates.

*Latham is required by Title VI of the Civil Rights Act of 1964 (Title VI), Section 504 of the Rehabilitation Act of 1973 (Section 504), Title IX of the Education Amendments of 1972 (Title IX), the Age Discrimination Act of 1975 (Age Act), and their respective implementing regulations at 34 C.F.R. Parts 100, 104, 106 and 110, not to discriminate on the basis of race, color, national origin, disability, sex, or age. Inquiries concerning the application of each of the aforementioned statutes and their implementing regulations to Latham may be referred to:*

Latham Centers, Inc., Vice President of Organizational Development Craig Anderson, (508) 896-5776 ext. 197 or 1646 Main Street (Route 6A) Brewster, MA 02631-1716, or to the U.S. Department of Education, Office for Civil Rights, at (617) 289-0111 or 5 Post Office Square, 8th Floor, Boston, MA 02109-3921

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**FOR AGENCY USE ONLY**

\_\_\_\_\_ Screening Interview \_\_\_\_\_ Assessment Visit  
 (date)  
 \_\_\_\_\_ Accepted \_\_\_\_\_ Rejected \_\_\_\_\_ Withdrew \_\_\_\_\_ Intake  
 (date)