APPLICATION FOR STEPHENS FARM AT ADEO

2780 28th Avenue
Greeley, CO 80634
970.339.2444

APPLICANT INFORMATION

Applicant's Name_____ Nickname: _____
Applicant's Social Security Number:_____ Date of Birth: _____
Current Address:_____
City: _____ State: _____ Zip:_____ Phone _____
Sex:__Height:_____ Weight:_____ Hair:_____ Eyes:_____
Primary Language:_____ Competent English Speaker: Yes___No___
Diagnosis:_____Date of onset of brain injury:_____
Explain how brain injury was acquired:_____
_____
Other Medical/Health Concerns:_____
Name of person filling out form: _____ Relationship:_____

FAMILY AND RESPONSIBLE PARTIES INFORMATION

Nearest Relative:_____ Relationship:_____
Address:_____
City: _____ State: _____ Zip: _____
Phone (Home):_____ Phone (Work):_____
Do you have a Guardian? Yes____ ____No ____ ____ If Yes, Who? _____
Name: _____
Phone (Home):_____ Phone (Work):_____
Do you have a Conservator? Yes____ ____ No____ ____ If Yes, Who? _____
Name: _____
Phone (Home):_____ Phone (Work):_____
Do you have a Durable Power of Attorney? Yes____ ____ No____ ____ If Yes, Who? _____
Name: _____
Phone (Home):_____ Phone (Work):_____
(Must provide copy of document designating guardian, conservator, Durable Power of Attorney)

STATUS PRIOR TO INJURY

Level of Education:_____Job Status:_____
Alcohol or drug abuse history:_____
Had you received treatment for alcohol and/or drug abuse? Yes____ No____
If Yes, where and when_____
Marital Status: _____
Any Children: Yes____ No____
Living Situation: _____
Had you been arrested: Yes____No____
Alleged Offense:_____Date:_____Outcome:_____
Alleged Offense:_____Date:_____Outcome:_____

CURRENT STATUS

MEDICAL

Do you require assistance with medications? Yes☐ No☐
Have you had or do you experience seizures? Yes☐ No☐
If Yes, are they controlled by medications? Yes☐ No☐
What is the date of your last seizure? _____
Do you see normally with both eyes? Yes☐ No☐
If No, please explain_____
Do you hear normally? Yes☐ No☐
If No, please explain_____
Do you have trouble controlling your bladder? Yes☐ No☐
If Yes, please explain_____
Do you have trouble controlling your bowels? Yes☐ No☐
If Yes, please explain_____
Do you have any eating/swallowing concerns? Yes☐ No☐
If Yes, please explain_____
Do you have problems affecting speech? Yes☐ No☐
If Yes, please explain_____
Do you have pain? Yes☐ No☐
If Yes, please explain_____
Do you smoke? Yes☐ No☐
If Yes, how much and how often?_____
Do you drink alcoholic beverages? Yes☐ No☐
If Yes, how much and how often?_____
Other medical concerns or special health needs:_____
_____

MOBILITY

Put a mark next to any of the following that you currently use:
power wheelchair, manual wheelchair, walker, cane, crutches, other_____
Do you need assistance with the use of the above? Yes☐ No☐
If Yes, please explain_____
Do you have problems with your balance? Yes☐ No☐
If Yes, please explain_____
_____
Can you go up and down stairs safely and independently? Yes☐ No☐
Do you need assistance with the following:
- Getting in and out of bed Yes☐ No☐
- Getting in and out of the shower Yes☐ No☐
- Getting on and off the toilet Yes☐ No☐
- Getting up or sitting down in a chair Yes☐ No☐

COGNITION

Do you have problems with the following?

Memory	Yes☐ No☐
Orientation to time, person or place	Yes☐ No☐
Confusion	Yes☐ No☐
Planning	Yes☐ No☐
Organization	Yes☐ No☐
Judgment	Yes☐ No☐
Initiating activities	Yes☐ No☐

Other (please specify)_____

EMOTIONAL AND BEHAVIORAL ADJUSTMENT

Do you have problems with:

Depression	Yes☐ No☐
Thoughts of suicide	Yes☐ No☐
Paranoia	Yes☐ No☐
Controlling your actions sexually	Yes☐ No☐
Alcohol or drugs	Yes☐ No☐

Do you get angry easily? Yes☐ No☐

If yes what causes this? _____

What are the best ways to help you calm down? _____

_____

How would you rate your frustration tolerance? (mark below)

Never frustrated☐ Sometimes frustrated☐ Always frustrated☐

What causes you to become frustrated?_____

_____

Do you ever verbally lose control?	Yes☐ No☐
Do you ever physically lose control?	Yes☐ No☐

When angry or under stress, do you:

Swear at others	Yes☐ No☐
Threaten others	Yes☐ No☐
Hit, push or physically attack others	Yes☐ No☐
Throw or break things	Yes☐ No☐
Do nothing	Yes☐ No☐
Run away	Yes☐ No☐

Other _____

EMOTIONAL AND BEHAVIORAL ADJUSTMENT

What time do you normally go to bed?_____

What time do you normally get up in the morning?_____

Do you get up at night? Yes☐ No☐

If yes, are you oriented to where you are.

Describe your mood if you get up at night. _____

_____

Are you currently receiving psychotherapies or psychiatric treatment? Yes☐ No☐

If Yes please explain the focus of treatment._____

_____

Name of person providing treatment and phone number:

Name:_____ Phone _____

ACTIVITIES OF DAILY LIVING SKILLS

Mark level of assistance required for each task	Independent	Cues or Supervision	Physical Assistance
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Brushing teeth or cleaning dentures	☐	☐	☐
Brushing and/or styling hair	☐	☐	☐
Shaving	☐	☐	☐
Feeding self	☐	☐	☐
Cooking	☐	☐	☐
Laundry	☐	☐	☐
Cleaning room/apartment	☐	☐	☐
Reading	☐	☐	☐
Writing	☐	☐	☐
Using telephone	☐	☐	☐

Do you drive? Yes☐ No☐

What are your hobbies?_____

_____

MEDICATION SHEET

What allergies do you have? _____

_____

Medications (mg, times per day)	Taken For
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____

If there are more than 15 medications put them on the back of this form.

FINANCIAL INFORMATION

Do you manage your own money? Yes_____ No_____

Representative Payee:_____

Please list the source of your income and amount:

( ) Social Security	Amount_____
( ) SSI	Amount_____
( ) SSDI	Amount_____
( ) Pension	Amount_____
( ) Alimony	Amount_____
( ) Disability Insurance	Amount_____
( ) Other	Amount_____

What type of insurance do you have? (Enclose copy of front & back of insurance cards)

Policy #_____ ID#_____

Company_____ Contact_____

Address_____ Phone (_____)_____

Policy #_____ ID#_____

Company_____ Contact_____

Address_____ Phone (_____)_____

Do you have Medicaid? Yes_____ No_____ If yes, Medicaid#_____State_____

Do you have Home and Community Based Services (HCBS)? Yes_____No_____

If yes, in what county?_____ Phone#_____

Who is your HCBS Case Manager?_____

Do you have Medicare? Yes_____ No_____ Part A_____ Part B_____

If yes, what is your Medicare#?_____

OTHER INFORMATION NEEDED WITH APPLICATION

1. Physicians History, Current Physical, Neuropsychological evaluation if available.

2. If receiving psychological services, a letter from the person providing services. It should explain the psychological condition of applicant, any concerns the therapist has, and the therapist's recommendation regarding your participation in this program.

Please return to:

Stephens Farm
2774 Reservoir Road
Greeley, CO 80634

If you have any questions please call Jenn Palmer, Director of Brain Injury Services, at (970) 506-0008.

VOLUNTEER SURVEY

Government agencies at times require periodic reports on the gender, ethnicity, veteran and other protected status of applicants. This data is for statistical analysis only. **Submission of this information is voluntary and in no way affects the application process.**
Check one: ☐ Male ☐ Female
Are you a veteran of the U.S. Armed Services? ☐ Yes ☐ No
Ethnicity/Race: (check only one) ☐ Black or African American, Not Hispanic or Latino ☐ American Indian or Alaska Native, Not Hispanic or Latino ☐ Asian, Not Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander, Not Hispanic or Latino ☐ Hispanic or Latino ☐ White, Not Hispanic or Latino