Shenandoah School of Hope

P.O Box 10, Linden, VA 22642
Phone: (540) 642-1200
Fax: (540) 486-5646

For Private Pay Candidates Only *- A $100.00 Application Fee (which is non-refundable) must accompany this application.*

Name of Applicant: _____
(First) (Middle) (Last)

Please attach a recent picture of applicant here

Date of Birth: _____

Social Security #: _____

Referring Agency: _____

For Shenandoah School of Hope Office Use Only

Date of entry: _____

Date of Graduation/Discharge: _____

Reason for Discharge: _____

_____

_____

A. Family Information:

1. Father (or Guardian)

Name: _____

Address: _____

_____
(City) (County)

_____
(State) (Zip)

Occupation: _____

Phone: (Home) _____

(Work) _____

(Cell) _____

Email: _____

Mother (or Guardian)

Name: _____

Address: _____

_____
(City) (County)

_____
(State) (Zip)

Occupation: _____

Phone: (Home) _____

(Work) _____

(Cell) _____

Email: _____

2. Person to be Notified in Emergency (other than either of the above):

Name _____ Relationship to Applicant _____

Phone: (Home) _____ (Other) _____

B. Information on Applicant:

1. Name of Applicant: _____
2. Address: _____
3. Birthplace: _____
4. Religion: _____
5. General description of the nature of applicant's disability: _____

_____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Source of Income: _____

Policy Group #:_____

Insurance Policy #:_____

Policy Start Date: _____

Policy End Date: _____

Insurance Company/Union Name and Address where claims are mailed:

_____

_____

_____

_____

_____

Insurance Covers (Check all that apply): ☐ Hospital Outpatient (i.e., lab work / physical therapy)
☐ Hospital Stays ☐ Doctor Visits ☐ Prescription Drugs
☐ Dental Care ☐ Vision Care ☐ Long-term care / nursing home

If applicant receives Virginia Medicaid, please supply Medicaid#: _____

7. Is applicant under medication at this time? Yes ____ No_____

Type / Frequency of administration: _____

Type / Frequency of administration: _____

Type / Frequency of administration: _____

8. Is applicant self-medicating? Yes_____ No_____

9. Allergies? (Food or Otherwise) Yes____ No____

10. List:_____

Allergy Medication:_____

11. Date of Last Physical: _____
Last Audiological: _____
Last Eye Exam: _____

12. Last Dental: _____
Last Psychological: _____
Last TB Test: _____

C. Medical and Physical:

1. Does applicant have any contagious conditions? Yes: ____ No____
   Explain:

   _____

   _____

2. Does applicant wear glasses? Yes: ____ No ____

3. Does applicant wear a hearing aid? Yes:____ No: ____

4. Does applicant wear braces, use crutches, etc.? Does applicant need assistance to walk?

   Explain: _____

5. Note any particular feminine problems: _____

6. Does applicant have any other special medical needs?

   _____

   _____

7. Note any childhood illness associated with high persistent fever: _____

   _____

8. Accidents: _____

9. Seizures (Dates / Severity):

   First occurrence: _____

   Latest occurrence: _____

   (b) Medication: _____

   (c) How well controlled: _____

10. Operations: _____

11. Coordination: Good ____ Fair____ Poor ____

12. Note any developmental anomalies, malformations, or stigmata: _____

    _____

13. Nervous Habits: (Tics, nail biting, etc.) _____

    _____

14. Present state of health: _____

15. Any significant history of trauma? _____

_____

_____

D. Educational Data: (List most recent first)

1. List Schools Attended:

School Name/Location	Year(s)	Grade Leve and Estimate of Performance Level

2. List any CBI experiences, paid employment, and volunteer experiences

Location	Year (s)	Duties Performed

3. List Facilities Attended:

Facility Name/Location	Year(s)	Estimate of Performance

2. Previous Attendance: Regular

3. Present placement: _____

4. List successful sources of motivation: Concrete _____

Verbal _____

E. Social Data:

1. Social Life: Home _____

Elsewhere _____

2. Withdrawn?_____ Outgoing?_____ Aggressive?_____

3. Gets along well with others? _____

4. Any organized group activities? _____

5. _____

6. Interests

List Likes: _____

List Dislikes: _____

Hobbies / Interests: _____

F. Family Relationships

1. Natural or Adopted child: ☐ Natural ☐ Adopted

2. Siblings - Name (s) and Age (s): _____

_____

3. Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

If not married, please note who has legal custody _____

If divorced, what is legal visitation agreement? _____

_____

4. Note presence of any family illness: _____

_____

5. Further comments: _____

_____

G. Skills Checklist:

Mobility: ☐ Ambulatory ☐ Ambulatory with cane or walker ☐ Uses Wheelchair: type: _____

Can Transfer from wheelchair Yes ____No____

Dressing:

Can pack / unpack self: ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Dresses self: ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Can tie shoes: ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Can button and Zipper ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Can distinguish between clean/dirty clothing ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Showering:

Takes a shower ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Shampoos hair ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Dries off ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Maintains body cleanliness ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Toileting:

Uses toilet appropriately ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Asks to use the toilet ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Can wipe ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Wears Depends: Yes _____ No _____ If yes, when are they worn? _____

Has a bathroom schedule: Yes _____ No _____ If yes, please describe: _____

Feeding:

Is able to use a fork ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Is able to use a spoon ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Is able to use a knife ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Is able to use finger food ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Is able to drink from a glass ☐ Independent ☐ Needs Verbal Prompts ☐ Needs Physical Assistance

Has the ability to eat a full serving: Yes _____ No_____

If no, please explain: _____Special Dietary Restrictions: Yes_____No_____
If yes, please explain:

_____

_____

Adaptive Equipment needed for Eating: Yes _____ No _____

Food Allergies: Yes___ No___

If yes, please list:

_____

Food Dislikes – please list:

_____

_____

Night Time Routine:

Normally sleeps through the night ☐ Yes ☐ Yes, with few exceptions ☐ No

If no, please describe any and all irregularities in sleeping habits:

_____

_____

Communication:

☐ Easily Communicates verbally ☐ Has difficulty communicating verbally ☐ Non-verbal

☐ Uses a Communication Book ☐ Uses an Assistive Device ☐ Uses American Sign Language

Behavioral Information:

Is able to occupy themselves during free time? ☐ Yes ☐ No

If no what type of supervision is needed during free-time?

_____

_____

When angry, what does the applicant do?

_____

_____

How frequently does the applicant get angry?

_____

What normally triggers the applicant's anger?

_____

_____

When the applicant is angry, are you able to redirect them and, if so, how?

_____

_____

Does the applicant have a current Behavioral Support Plan? ☐ No ☐ Yes. **If yes, please attach.**

Has the applicant ever been restrained? ☐ No ☐ Yes. If yes, when did this last occur and please describe circumstances:

_____

_____

_____

Reinforcers for positive behavior:

_____

Swimming:

Can go swimming: ☐ Yes ☐ No Can submerge head under water: ☐ Yes ☐ No

Will enter pool with assistance: ☐ Yes ☐ No Can float and get face wet:☐ Yes ☐ No

Can use a kickboard: ☐ Yes ☐ No Can swim independently in deep end: ☐ Yes ☐ No

Can support self in water, using specific stroke: ☐ Yes ☐ No

Estimated Swimming competence and comments:

_____

_____

Indicate which program you would like to participate in (check as many as apply)

- ☐ Sustainable and Organic Farming Methods
- ☐ Viticulture and Introduction to Winemaking
- ☐ Animal Husbandry
- ☐ Facilities, Grounds and Forestry Maintenance
- ☐ Food Service
- ☐ Auto Mechanic Training

I. Reference Information

How did you hear about Shenandoah School of Hope Programs & Services?

_____

_____

Why are you seeking admission to Shenandoah School of Hope Programs & Services for your son/daughter?

_____

_____

Is there any other pertinent information that you would like to share with us regarding the Applicant?

_____

_____

_____
(Parent or Legal Guardian Signature) (Date)

_____
(Applicant Signature) (Date)

_____
(Address)

_____
(City, County, State and Zip Code)

_____ _____
(Home Telephone #) (Mobile Telephone #)

_____
(Contact Person Email Address)

The Shenandoah School of Hope admits students of any race, color, gender, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, gender, national and ethnic origin in admission of its educational policies, admissions policies, scholarship and loan programs, and athletic and other school-administered programs.