



## Admission Referral Form

This form must be completed for every person applying for STAR services. Please return this form, when complete, to STAR's Director of Employment Services.

Name of person completing form: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_ Date: \_\_\_\_\_

### General Information:

Applicant name: \_\_\_\_\_  
Last First Middle

Referred by: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Religious preference: \_\_\_\_\_

Language(s) spoken or understood: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Length of time at address: \_\_\_\_\_

Others residing at residence:

Name Relationship to Applicant: Age:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have plans to move within the next year? Y/N Where? \_\_\_\_\_

**Father's Name:** \_\_\_\_\_  
Father's address (if different from above): \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)  
Occupation: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_  
Mother's address (if different from above): \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)  
Occupation: \_\_\_\_\_

**Sibling(s) Living Apart from Applicant**

Birthdate: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list two people **other than** parents/guardian or people who live with the applicant who can serve as emergency contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to applicant: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to applicant: \_\_\_\_\_

**Legal Guardian** (if any):

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)  
Date of Court Appointment: \_\_\_\_\_

*Please attach a copy of the guardianship or conservatorship papers.*

**Please describe the services or supports you would like to obtain from STAR.**  
(ie. Support in obtaining and maintaining employment, respite services, access to the community, organized recreation.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What accomplishments or desired outcomes can STAR assist the applicant in achieving within the next year?

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Have you applied for, received, or are currently receiving services from other agencies? ( ) Yes ( ) No If so, what agencies?

Department of Mental Retardation  
Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Bureau of Rehabilitation Services  
Counselor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date services last received: \_\_\_\_\_ Case Status: (circle) Open / Closed

Other: (Please provide name and phone of contact person.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Public Assistance/Entitlements                      Start Date    Amount                      Number**

Supplemental Security Income (SSI)			
Social Security (SSA/SSDI)			
State Supplement			
Medicaid			
Medicare			
V.A. Benefits			
Food Stamps			
Housing Subsidy			
(other)			

Other sources of Income/Support:

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**Medical Information**

**Medical Care**

Private Health Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Current Physician: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Address: \_\_\_\_\_

Current Neurologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Optometrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Pharmacist: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Specialists: \_\_\_\_\_ Phone: \_\_\_\_\_

**Seizures**

Does Applicant have seizures? Y / N

If yes, what type(s)? (Describe)

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Date of last seizure: \_\_\_\_\_

How often do seizures occur? \_\_\_\_\_

Do seizures typically occur at certain times of the day? Y /N (if yes, when?)

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Typical duration of seizure (minutes): \_\_\_\_\_

Factors that trigger seizures: \_\_\_\_\_

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Any warning or sign that seizure is about to occur? \_\_\_\_\_

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Condition after seizures: (how long to recover?) \_\_\_\_\_

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Has applicant ever gone into status (continued seizure activity for more than five minutes, going from one seizure immediately into another)? Y / N

**Prescription Medications:**

Name                      Dose   Times   Reason for taking              Doctor              Side Effects

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**Over the Counter Medicines:**

Name            Dose   Times   Reason for taking            Drug Interactions            Side Effects

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Does applicant self-administer medication? Y / N

If yes, with or without supervision? \_\_\_\_\_

**Allergies:**

Is applicant allergic to any medications? Y / N

Is applicant allergic to any foods? Y / N

Is applicant allergic to anything else? Y / N

Please specify allergy(s), describe reaction, and explain emergency measures.

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Is the applicant on a special diet ordered by a physician? Y / N

Physician: \_\_\_\_\_ Date started: \_\_\_\_\_

Type of diet: \_\_\_\_\_ Reason for diet: \_\_\_\_\_

Any other dietary restrictions? \_\_\_\_\_

**Hospitalizations:**

Date/Duration            Reason            Name/address of hospital

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**Illnesses and Diseases (Note year)**

Chicken Pox _____	German Measles _____	Tuberculosis _____
Measles _____	Polio _____	Hepatitis A _____
Mumps _____	Whooping Cough _____	Hepatitis B _____
Scarlet Fever _____	Rheumatic Fever _____	Hepatitis C _____
Cardiac _____	Diabetes _____	Other _____
Cancer _____	Pneumonia _____	_____
Psychiatric _____		_____

***Please provide Immunization Record.***

Is applicant prone to any of the following? (Check if yes)

Asthma _____	Strep Throat _____	Colds _____
Constipation _____	Nose Bleeds _____	Diarrhea _____
Vaginal Infections _____	Urinary Tract Infection _____	
Weight Gain/Loss _____		

Other (Please Explain)

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Does the applicant have vision or hearing problems? Y / N

If yes, please explain: \_\_\_\_\_

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**Females Only:**

Age menstruation began: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Does applicant have regular monthly periods? Y / N

If no, please explain: \_\_\_\_\_

Does applicant regularly experience problems or difficulties at any point in her menstrual cycle? Y / N

If yes, please explain: \_\_\_\_\_

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**Accommodations, Adaptive Equipment , Assistive Technology**

Does the applicant require any equipment to accommodate for problems performing life functions: communication, locomotion, eating, etc.? (examples: braces, walker, wheelchair, communication device, hearing aid, glasses, specialized eating utensils) Please specify:

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**Personal Information:**

Does the applicant need assistance with personal care tasks? (Please specify which tasks and what assistance) \_\_\_\_\_

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What responsibilities (chores) does applicant regularly assume at home? (With/without assistance?) \_\_\_\_\_

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What are the applicant's favorite activities to do at home? \_\_\_\_\_

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What are the applicant's favorite things to do/places to go in the community?

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What hobbies, or special interests does the applicant have? \_\_\_\_\_

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Does the applicant belong to any clubs or organizations or regularly participate in any organized community activities? \_\_\_\_\_

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Does the applicant have any specific fears or strong aversions? (What?)

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How would you generally describe the applicant? (outgoing, loner, assertive, argumentative, cooperative, etc.) \_\_\_\_\_

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**Educational Information:**

**Educational History**

**Name of School                      Location                      From   To                      Last grade/diploma**

Name of School	Location	From	To	Last grade/diploma

**Functional Academic Skills** (Please check skills the applicant has and briefly explain)

**Math**

- Matching \_\_\_\_\_
- Number recognition \_\_\_\_\_
- Counting (To ?) \_\_\_\_\_
- Counting by intervals \_\_\_\_\_
- Addition (single/multiple digits, carrying) \_\_\_\_\_
- Subtraction (single/multiple digits, borrowing) \_\_\_\_\_
- Multiplication (single/multiple digits) \_\_\_\_\_
- Division (single/multiple digits) \_\_\_\_\_
- Using Calculator \_\_\_\_\_

- ( ) Recognize coins and bills (which?) \_\_\_\_\_
  - ( ) Make change (up to ?) \_\_\_\_\_
  - ( ) Purchase and receive correct change \_\_\_\_\_
  - ( ) Checking Account \_\_\_\_\_
  - ( ) Tell time (Regular/ digital, to what interval?) \_\_\_\_\_
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- ( ) Follow time schedule \_\_\_\_\_
  - ( ) Know days of week \_\_\_\_\_
  - ( ) Use calendar \_\_\_\_\_

**Reading**

- ( ) Letter Recognition \_\_\_\_\_
- ( ) Recognize safety signs \_\_\_\_\_
- ( ) Sight words \_\_\_\_\_
- ( ) Alphabetize (to 1<sup>st</sup>, 2<sup>nd</sup>, ? Letter) \_\_\_\_\_
- ( ) Follow written schedule \_\_\_\_\_
- ( ) Read for pleasure or information (specify reading material) \_\_\_\_\_

**Please describe any school based or community based work experience the applicant had as a student. Please include the dates of experience and the supervising staff.**

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**Work and Volunteer Experience:**

**Volunteer Experience**

Agency: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Supervisor: \_\_\_\_\_  
 Describe worked performed: \_\_\_\_\_  
 Reason for leaving: \_\_\_\_\_

Agency: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Supervisor: \_\_\_\_\_  
 Describe worked performed: \_\_\_\_\_  
 Reason for leaving: \_\_\_\_\_

Agency: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Address: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Describe worked performed: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Agency: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Address: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Describe worked performed: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**Work History:**

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Supervisor Name: \_\_\_\_\_ Supervisor Title: \_\_\_\_\_

May we contact? Y / N

Applicant's Job Title: \_\_\_\_\_

How did applicant get this job? \_\_\_\_\_

Job Duties: \_\_\_\_\_

Was extra training provided? By whom? \_\_\_\_\_

Start Date: \_\_\_\_\_ Start Salary: \_\_\_\_\_ Starting Hours: \_\_\_\_\_

End Date: \_\_\_\_\_ End Salary: \_\_\_\_\_ Ending Hours: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Supervisor Name: \_\_\_\_\_ Supervisor Title: \_\_\_\_\_

May we contact? Y / N

Applicant's Job Title: \_\_\_\_\_

How did applicant get this job? \_\_\_\_\_

Job Duties: \_\_\_\_\_

Was extra training provided? By whom? \_\_\_\_\_

Start Date: \_\_\_\_\_ Start Salary: \_\_\_\_\_ Starting Hours: \_\_\_\_\_

End Date: \_\_\_\_\_ End Salary: \_\_\_\_\_ Ending Hours: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Supervisor Name: \_\_\_\_\_ Supervisor Title: \_\_\_\_\_

May we contact? Y / N

Applicant's Job Title: \_\_\_\_\_

How did applicant get this job? \_\_\_\_\_

Job Duties: \_\_\_\_\_

Was extra training provided? By whom? \_\_\_\_\_

Start Date: \_\_\_\_\_ Start Salary: \_\_\_\_\_ Starting Hours: \_\_\_\_\_  
End Date: \_\_\_\_\_ End Salary: \_\_\_\_\_ Ending Hours: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

**Contact with Criminal Justice System:**

Contact with the criminal justice system does not exclude an applicant from receiving services. To effectively plan services and supports and to effectively represent a participant, STAR needs a full and accurate account of any and all contact with the criminal justice system. All information provided will be treated in confidence.

Has the applicant ever been arrested? Y/N  
If yes, when? \_\_\_\_\_  
What was the charge? \_\_\_\_\_  
\_\_\_\_\_

Is the applicant currently under indictment? Y/N  
If yes, what are the charges? \_\_\_\_\_  
Trial date? \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

Has the applicant ever been convicted of a crime? Y/N  
If yes, what? \_\_\_\_\_  
What was the sentence? \_\_\_\_\_  
Is the applicant currently on probation? Y/N  
Is the applicant currently on parole? Y/N  
Name of probation/parole officer \_\_\_\_\_ Phone: \_\_\_\_\_  
What are the terms and length of probation/parole? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9/89  
9/92 Revised  
9/95 Revised  
2/98 Revised  
2/00 Revised