

APPLICATION & ADMISSION PROCEDURES

Farm in the Dell - Butte c/o
Farm in the Dell, International Foundation
1208 Poplar
Helena, MT 59601



APPLICATION

1. Contact Farm in the Dell, International Foundation for Application Packet.
2. Complete the following forms:
 - a. Application form
 - b. Sign "Release of Information" form
 - c. Sign "Medical and Extended Care" agreement
 - d. Sign the waiver
 - 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an applicant have a psychological evaluation and/or a vocational assessment if these are not available or have become outdated.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 \$1340.00 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

The Farm in the Dell is not simply a training or pass through program, but rather a place a person can make a permanent home. The program offers a 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 other community groups support the emotional and social needs of the residents.

APPLICATION FOR ADMISSION

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Farm in the Dell, International Foundation
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:

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 | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Flosses teeth | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Uses deodorant | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Shampoos hair | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Grooms hair | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Shaves | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Washes hands | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Takes bath/shower alone | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Uses toilet paper | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Menstrual care | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

Comments: _____

Housekeeping:

- | | | | | |
|-------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Cleans room | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Makes bed | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Washes clothes | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Puts clothes away | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Washes dishes | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Dries dishes | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Sets & clears the table | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Vacuums carpets | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Dusts furniture, etc. | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Sweeps floors | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Wet mops the floor. | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Empties the trash | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Shovels snow | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Irons clothing | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Mends clothing | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Mows lawn | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

Comments: _____

Socialization and Community Skills:

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

Comments: _____

Independence:

- | | |
|--|--|
| Gives knowledge of self (name, address & tele.) | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Operates home appliances safely | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Uses telephone | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Recognizes need for medical services | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Seeks medical help in an emergency | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Recognizes vital signs in another | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Takes own medications | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Sets alarm clock for getting up on time | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Goes to bed at a required time | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Keeps perishable food for safe lengths | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Fixes breakfast & lunch for self | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Fixes at least two different evening meals | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Safely uses a sharp kitchen knife | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Does home repair and maintenance | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Uses electric equipment (drill, food mixer, saw etc) | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Uses sewing machine | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Uses washer/dryer | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Has knowledge of fire safety | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Leaves building at the sound of fire alarm | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |

Comments: _____

Activities & Interests:

- | | |
|---|--|
| Initiates hobbies during "free time" | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Participates in leisure activities | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Enjoys going on outings such as picnics etc | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Has shown responsibility with owning a pet | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Comfort around small animals (cats, dogs) | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Comfort around large animals (cows, sheep) | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Likes the out-of-doors | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Enjoys gardening | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| Has worked in a garden | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Knows how to swim | <input type="checkbox"/> Yes <input type="checkbox"/> 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:

Physician's name: _____

Address _____

Telephone _____

Date of last physical: _____ Visit: _____

Results: _____

Dentist's name: _____

Address _____

Telephone _____

Date of last physical: _____ Visit: _____

Results: _____

Does applicant currently require any dental work? Yes No

Explain: _____

Eye doctor's name: _____

Address _____

Telephone _____

Date of last physical: _____ Visit: _____

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

Hearing doctor's name: _____

Address _____

Telephone _____

Date of last physical: _____ Visit: _____

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 if the condition is past, current or has never happened.

(check one)	Past	Current	Never
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired sight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Goiter or enlarged thyroid.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Skin Disease (name): _____

Chronic or frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up of blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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 _____
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) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Measles or German Measles. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Chicken pox or Mumps. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Whooping cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Scarlet fever or Scarlatina. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Pneumonia or Pleurisy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Diphtheria or Smallpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Influenza | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Rheumatic fever or heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Heart murmur. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Arthritis or Rheumatism. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Any bone or joint disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Neuritises or neuralgia. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Bursitis, sciatica or lumbago | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Polio or meningitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Back or foot problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Bright's disease or kidney infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Gonorrhoea or Syphilis. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Anemia or jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Migraine headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Tuberculosis. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Diabetes or Cancer. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| High or low blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Food, chemical or drug poison | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hay fever or Asthma. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hives or Eczema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Frequent colds or sore throat. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Bronchitis. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Mononucleosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Frequent infections or boils | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| HIV Positive or AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Any other diseases? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

If Yes explain: _____

PART 8

Seizures:

Does the applicant have any history of seizures?

- Yes No

If Yes explain: _____

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)

			Date:
Smallpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Typhoid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Mantoux (TB).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diphtheria-Tetanus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Polio or meningitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
DPT.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Polio Series	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Measles/Mumps/Rubella.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

PART 10

Allergies: (Please check all that apply)

			Reaction:
Penicillin.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Aspirin, Codeine or Morphine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Mycins or other antibiotics.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Merthiolate or Mercurochromes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Tetanus Antitoxin or Serums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bee stings.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Any other drug	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Any foods.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Adhesive tape	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Nail polish or other cosmetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Others : _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 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)

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____
Epilepsy.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Tuberculosis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High Blood Pressure.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Mental Illness.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Suicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Congenital Deformities.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Back Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Foot Problems.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Spasticity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cerebral Palsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

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

Farm in the Dell Butte Home & 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 Christian 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 - Butte c/o
Farm in the Dell, International Foundation
1208 Poplar
Helena, MT 59601**

RELEASE OF INFORMATION

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

_____ to Farm in the Dell.

Name of Applicant

SIGNATURE DATE RELATIONSHIP TO APPLICANT

NOTARY PUBLIC DATE