Special K Ranch
P.O. Box 479
Columbus, MT 59019

APPLICATION AND ADMISSION PROCEDURES FOR SPECIAL K RANCH

APPLICATION

1. Contact Special K Ranch for an Application Packet.
2. Complete the following forms:
   a. Application Form
   b. Sign "Release of Information" form.
   c. Sign "Medical and Extended Care" form
3. A complete Medical History is to be included with the application along with School Reports, Psychological Evaluations, and Vocational Reports. The Screening Committee May request that an applicant have a Psychological Evaluation and/or a Vocational Performance Work-up if one has not been done in the past year.
4. Return Completed Application to Special K Ranch
5. When an opening becomes available, the Screening Committee will notify you if the Applicant is being considered for the opening The Application will be kept on file until/unless we are advised you wish to withdraw it from future consideration.

ADMISSION

1. When the Screening Committee determines that the Applicant is a candidate for placement and an opening exists, an Interview will be scheduled with the Applicant, the Parents/Guardians and the Screening Committee. If no openings are available, the Applicant will be placed on the waiting list and will be notified when an opening occurs.
2. Following the Interview, the Screening Committee will meet to decide whether or not the Applicant will be accepted for a six (6) week trial period. The Applicant will be notified of the committee decision.
3. When an Applicant is accepted, arrangements will be made for the date of arrival and a list of things the Applicant will need to bring will be sent.

4. The following requirements must be met before the Applicant moves to Special K Ranch:

   a. A satisfactory method of payment will be established
   b. A recent dental check-up, (within last 6 months)
   c. A complete physical examination (within last 6 months)
   d. Any requirements concerning medications, special treatment or diet, must be in writing with a physician's note, if possible, and medication should accompany Applicant.
   e. All paperwork, i.e. W-2's, I-9's, Photo Release, etc. must be filled out.

5. Upon arrival, the Applicant is received as part of the program for a six (6) week trial period. At the end of trial period, a written evaluation will be made by the staff and shared with the Applicant and/or Parents or Guardians. At this time a final determination on the acceptance of the Applicant will be made.

6. If at any time payment becomes 60 days delinquent, Parents or Guardian must be prepared to pick up their son or daughter.

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Application for Admission

PLEASE PROVIDE A RECENT PHOTOGRAPH OF APPLICANT WITH APPLICATION

Applicant Information Date_________________
(filled out)

Name____________________________________ Date of Birth_______________________

Sex________Place of Birth_____________________________SS#_______-______-______

Place of Residence ____

Religious Affiliation____

REFERRAL SOURCE (if any)

	Organization	School	Physician
Name	_______________	_____________	_______________
Address	_____________	_____________	_______________
City & State	_____________	_____________	_______________
Phone No	___________	_____________	_______________

Is client's primary handicap mental retardation? Yes _______ No______________

Explain____

Family of Applicant

Father's name ___________________________________Home Phone______________

Address______________________________________Zip Code_____________

Employer________________________________Business Phone_____________

Mother's name __________________________________Home Phone_______________

Address______________________________________Zip Code_____________

Employer________________________________Business Phone_____________

Legal Guardian of Applicant:____

Address_______________________________________Zip Code_____________

Relationship to Applicant____

Give name, age and address of brother and/or sisters of applicant:

Name Age Address

__________________________ _____ _____________________________

__________________________ _____ _____________________________

__________________________ _____ _____________________________

In Emergency Call:_________________________ Phone no.__________________

PHYSICAL DESCRIPTION

Present Height____________ Height a Year Ago_________

Present Weight____________ Weight a Year Ago_________

Difficulty with Vision?____

Difficulty Hearing?____

Coordination:

Gross Motor Coordination_____Excellent ______Good ______Poor

Fine Motor Coordination ______Excellent ______Good ______Poor

Able to: Walk up stairs ____________________ Run ___________________

Rides bicycle ______________________ Rides Horses __________________

Physical Limitations____

For What Reason ____

COMMUNICATION

Speech:

Clear__________________________ Words ___________________________

Intelligible______________________ Phrases __________________________

Indistinct ______________________ Sentences_________________________

Comprehension:

Everything ______________________ Partially _________________________

Follows simple direction____

Answers a simple question____

SELF CARE

Eating:

Feeds Self_____________________ Under Supervision ___________________

Uses Fork ________________ Spoon _____________ Knife to cut__________

Personal:

Brush teeth unaided _______________ Wash hands unaided_________________

(Self Care continued)

Take bath/shower alone ____

Take care of self at toilet____

Wets self________________________ Wets bed __________________________

Dress and undress self; manage buttons, zippers, laces, belt, __________________

Cuts own nails____

Need for Supervision: _____________Constant _________________Moderate

Can be Left Alone: ________________Inside ________ __________Outside

BEHAVIOR (Underline characteristics of applicant that apply)

Calm – Cooperative – Hyperactive – Aggressive – Alert - Industrious – Apathetic –

Irresponsible – Lazy – Social- Reclusive – Cheerful – Moody – Stubborn –

Antagonistic – Easily Corrected – Honest – Destructive – Runs Away –

Cries Easily – Temper – Difficult to Manage –

How is time occupied when alone? _______________________________________

Behavior in public when with you? _______________________________________

What sort of things cause anxiety or disturbance? __________________________

____

Explain in detail behavior when disturbed:_________________________________

____

Additional Comments related behavior: ____________________________________

____

SOCIALIZATION SKILLS

Gets along well with peers of same sex? __________________________________

Gets along well with peers of opposite sex? _______________________________

Gets along well with adults of same sex? _________________________________

Gets along well with adults of opposite sex? _______________________________

(Socialization Skills continued)

Makes friends easily? ____

Accepts constructive criticism? ____________________________________

Is willing to help when asked? _____________________________________

Related well with authority figures? _________________________________

Participates in group activities? ____________________________________

INTERESTS

Likes animals _________________ Been around animals ________________

What kind?____________________ Likes outdoors _____________________

Outdoor interests and/or abilities ___________________________________

____

Indoor interests and/or abilities _____________________________________

____

EDUCATION

Can read_____________ Can Count ___________ How High?_____________

Use pencil ___________________ Scissors __________________________

Writes words _________________ Simple sentences ____________________

Attended school through what grade?__________ Graduated? _______________

Equivalent grade if known ____

Schools attended:

Name____________________________________ Dates attended___________

Complete address:____

Is school: Public____________ Private____________ Special___________

Name____________________________________ Dates attended___________

Complete address:____

Is school: Public____________ Private____________ Special___________

Name____________________________________ Dates attended___________

Complete address:____

Is school: Public____________ Private____________ Special___________

Name____________________________________ Dates attended___________

Complete address:____

Is school: Public____________ Private____________ Special___________

Residential Care facilities:

Name____ Dates attended____________

Complete address:____

Reasons or factors surrounding discharge: ____________________________________

____

Institutions, foster homes, etc.:

Names and complete addresses Dates

____ ________________________

____ ________________________

____ ________________________

MEDICAL CARE

Physician's name________________________ Address_____________________________

Phone No.______________________________ Date of last physical: _____________

Eye doctor's name _______________________ Address ____________________________

Phone No. _____________________________ Date of last exam ________________

Dentist's name __________________________ Address_____________________________

Phone No. _____________________________ Date of last exam_________________

Hospitalization Insurance with:____

Policy No._____________________________

Medical/Surgical Insurance with:____

Will insurance cover dental/eye expenses?____________________________________

Additional Information: ____

Past Surgery and/or treatments:

Tonsillectomy___________________________ When ___________________

Appendectomy___________________________ When ___________________

Other operation?__________________________ When ___________________

Transfusion? Blood or Plasma______________ When ___________________

Hernia__________________________________ When ___________________

Has recommendation been made for applicant to have other surgery not yet performed?____

Give details for this or any other surgeries above_________________________

____

MEDICAL HISTORY

Present health/condition:__________Good _________Fair ___________Poor

PLEASE MARK BELOW WITH A "C" FOR CURRENT OR "P" FOR PAST CONDITION

Eye disease____, Eye injury____, Impaired vision____, Ear injury____, Impaired hearing, Nose____, Sinuses____, Throat____, Fainting spells____, Loss of consciousness____, Convulsions____, Paralysis____, Frequent or sever headaches____, Dizziness_____, Depression or Anxiety____, Visual hallucinations____, Auditory hallucinations____, Enlarged glands_____,
Goiter or enlarged thyroid____, Skin disease____, Chronic or frequent cough____,
Chest pain/Angina pectoris____, Spitting/coughing up blood____, Night sweats____, Shortness of breath____, Varicose veins_____, Palpitations/fluttering heart_____,
Swelling of hands/feet/ankles____, Extreme tiredness/weakness____, Kidney disease or stones____, Bladder infection_____, Albumin, sugar, us, etc. in urine_____, Difficulty urinating____, Incontinent_____, Indigestion/acid reflux___, Stomach trouble or ulcers____, Liver or gallbladder disease____, Colitis or other bowel disease_____, Appendicitis_____,
Hemorrhoids or rectal bleeding____, Constipation or diarrhea____,

Medications: Does applicant take any prescribed drugs? ____________________
If yes, please list them and give dosage and directions for taking them: ____________
____
____
Does applicant take any other medications or vitamins regularly or frequently?____________________ If so what?______________________________
____
Does applicant administer own medication?________________________________

OTHER HEALTH INFORMATION

Cause of Mental Retardation:____
Has applicant ever had a psychological evaluation?__________________________
If so, when was it given?_________Who made the evaluation?________________
Other doctors, neurologists, pediatricians, allergists, chiropractors, etc. seen in the past: ____
____
____

Personal health history – please encircle all either yes or no and explain when ___

Measles/German measles	No	Yes	When	__________________
Chicken Pox/Mumps	No	Yes	When	__________________
Whopping cough	No	Yes	When	__________________
Scarlet fever/Scarlatina	No	Yes	When	__________________
Pneumonia/Pleurisy	No	Yes	When	__________________
Influenza	No	Yes	When	__________________
Rheumatic fever/Heart disease	No	Yes	When	__________________
Heart murmur	No	Yes	When	__________________
Arthritis or Rheumatism	No	Yes	When	__________________
Bone or Joint disease	No	Yes	When	__________________
Neuritis or Neuralgia	No	Yes	When	__________________
Bursitis, Sciatica or Lumbago	No	Yes	When	__________________
Polio or Meningitis	No	Yes	When	__________________
Back or Foot problems	No	Yes	When	__________________

(Personal health history - continued)

Bright's disease/Kidney infections	No	Yes	When	____________________
Gonorrhea/Syphilis/STD	No	Yes	When	____________________
Hepatitis A B or C/Jaundice	No	Yes	When	____________________
Anemia or Blood Disease	No	Yes	When	____________________
Epilepsy or Seizures	No	Yes	When	____________________
Migraine headaches	No	Yes	When	____________________
Diabetes	No	Yes	When	____________________
Cancer	No	Yes	When	____________________
High or Low Blood Pressure	No	Yes	When	____________________
Food, Chemical or Drug Poison	No	Yes	When	____________________

Chronic problems	Please circle	If yes please explain
Hay fever/Asthma	No	Yes________________________
Hives/Eczema/Dermatitis	No	Yes________________________
Colds/Sore throat/Bronchitis	No	Yes________________________
Mononucleosis	No	Yes________________________
Hernia	No	Yes________________________
Frequent infections/boils	No	Yes________________________
Other____________________	No	Yes________________________

Immunizations:	Please circle	If yes, date last received
Smallpox	No	Yes________________________
Typhoid	No	Yes________________________
Mantoux	No	Yes________________________
Tetanus	No	Yes________________________
D.P.T.	No	Yes________________________
Polio Series	No	Yes________________________
Flu	No	Yes________________________
Pneumonia	No	Yes________________________

Allergies:	Please circle	If yes please explain
Penicillin	No	Yes________________________
Aspirin	No	Yes ________________________
Codeine/Morphine	No	Yes ________________________
Mycins/other antibiotics	No	Yes ________________________
Merthiolate/Mercurochrome	No	Yes ________________________
Iodine	No	Yes ________________________
Any other drug___________	No	Yes ________________________
Any foods _______________	No	Yes ________________________
Adhesive tape	No	Yes ________________________
Nail polish/cosmetics	No	Yes ________________________
Tetanus, antitoxins/serums	No	Yes ________________________
Bee stings	No	Yes ________________________
Other ____________________	No	Yes ________________________

Diet: Is applicant on a regular diet? ___________Special diet?_________________

If special diet, please give reason and type of diet:_____________________________

____

Women Only: Menstrual History: Age at onset______________________

Flow: ________Heavy ________Medium ________Light ________ Regular _______ Irregular

Cycle: ____________days (from start to start next month) Usual duration: _________________days

Pain or cramps? _________________ If yes what is usually done?_____________________________

Date of last exam/PAP smear? ______________________Results______________________________

Does applicant care for herself during menstruation?____

Additional comments:____

Family History: Age If living/health If deceased/age at death & cause ___

Father ____

Mother ____

Siblings ____

____

____

Family Medical History	Please circle		If yes explain who
Cancer	No	Yes	Who______________________
Tuberculosis	No	Yes	Who ______________________
Diabetes	No	Yes	Who______________________
Heart Problems	No	Yes	Who______________________
High Blood Pressure	No	Yes	Who______________________
Stroke	No	Yes	Who______________________
Epilepsy	No	Yes	Who______________________
Mental Illness	No	Yes	Who______________________
Suicide	No	Yes	Who______________________
Arthritis	No	Yes	Who______________________
Congenital Deformities	No	Yes	Who______________________
Back Problems	No	Yes	Who______________________
Foot Problems	No	Yes	Who______________________
Spasticity	No	Yes	Who______________________
Cerebral Palsy	No	Yes	Who______________________

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 becomes part of this record will be regarded as confidential.

Signature of Parent or Guardian__________________________

_________Day of _________________, 200_____

Notary Public____________________________________

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MEDICAL AND EXTENDED CARE AGREEMENT

I/We, the undersigned, do hereby agree to be responsible for the payment of all medical expenses incurred by ____________________________ while a resident at Special K Ranch. I/We further agree to provide the necessary clothing for __________________________ until the time H/She is financially able to provide for his/her own needs.

Parent____________________________

Guardian__________________________

In the event of an emergency, injury or illness, I do hereby authorize the Program Director of Special K Ranch, or another staff member of Special K Ranch, to give consent for medical treatment for my ward/son/daughter/sister/brother.

Parent____________________________

Guardian__________________________

Signature of Parent or Guardian__________________________

_________Day of _________________, 200_____

Notary Public____________________________________

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Consent for Release of Confidential Information

To:________________________________

____

____

I, ________________________________, Applicant/Legal Guardian, authorize the above named to disclose to the Special K Ranch, Mike T. Oberg, Program Director, for the purpose of consideration of the application for residency at Special K Ranch of (Name of Applicant) _________ ______________________________ such confidential information as requested.

I understand that these records are protected under the Federal Confidentiality Regulations, and cannot be disclosed without written consent, unless otherwise provided for in the Regulations. I also understand that this consent may be revoked at the time the above leaves the residency program at Special K Ranch.

Executed this ________Day of ___________________, 200_____

____   __________________________________
Signature of Applicant or Legal Guardian   Print name

____   __________________________________
Signature of Witness   Print name

Information Requested by:

____   Date _____________________________
Mike T. Oberg, Program Director
SPECIAL K RANCH

FOR OFFICE USE ONLY BELOW THIS LINE ____

____ Date reviewed____________

Signature of Special K Ranch Screening Committee member reviewing the Application

Printed name____ Title ____________________

Comments/Notes on Application or Interview:____