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 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 we will send out a list of things the Applicant will need to bring.

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. Three (3) personal letters of reference for resident & his/her family.

c. A recent dental check-up (within last six (6) months).

d. A complete physical examination (within last six (6) months).

e Any requirements concerning medications, special treatment or diet, must be in writing with a physician's note, if possible, and medication should accompany Applicant.

f. All paperwork, i.e., W-2's, I-9's, photo release form, mortuary request form, etc. must be filled out.

g. Social Security Card, State ID, insurance cards, and a certified copy of live birth certificate.

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. Resident's family must be cognizant of the fact that the resident's SSI or Social Security does not fully cover the costs of residence at Special K Ranch. Assistance with securing donations to make up this shortfall is necessary for the financial well-being of the general operating fund for the Ranch.

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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 Applicant's primary disability a developmental disability? ______________________

Diagnosis/condition ____

Cause of disability ____

Family of Applicant

Father's name _____________________________________Home phone______________

Address____ Zip code_____________

Employer__________________________________ Business phone____________

Email____

Mother's name ____________________________________Home phone______________

Address____ Zip code______________

Employer___________________________________ Business phone______________

Email ____

Legal guardian of Applicant: ____

Address____ Zip code_______________

Relationship to Applicant____

Email____

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? ___________________

Any physical limitations? ____

For what reason? ____

COMMUNICATION

Speech: (Mark all that apply)

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? _________________________________

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: ___________________________

____

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

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	_____________________
Whooping 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 ____________________
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 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______________________

Family History:	Age	If living/health	If deceased/age at death & cause
Father			
Mother			
Siblings			

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 _________________, 20____

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 he/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 Residential Director or 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, Marvin G. Schieldt, Program Director or Kathy Lee, Residential 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 ___________________, 20_____

__________________________________ __________________________________

Signature of Applicant or Legal Guardian Print name

__________________________________ __________________________________

Signature of witness Print name

Information requested by:

__________________________________ Date______________________________

Marvin G. Schieldt, Program Director or
Kathy Lee, Residential 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:____