



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)

<u>Organization</u>	<u>School</u>	<u>Physician</u>
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	_____
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	_____

(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	_____

<u>Chronic problems</u>	<u>Please circle</u>	<u>If yes please explain</u>
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 _____

<u>Immunizations:</u>	<u>Please circle</u>	<u>If yes, date last received</u>
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 _____

<u>Allergies:</u>	<u>Please circle</u>	<u>If yes please explain</u>
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

<u>Family Medical History</u>	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:

Mike T. Oberg, Program Director
SPECIAL K RANCH

Date _____

