



# The Resting Tree

Owned and operated by THE GROUND UP PROJECT

Date: \_\_\_\_\_

Requested Start Date: \_\_\_\_\_

## Applicant Information

Name:		DOB:	
Race:	Gender:		Age:
Address:			
City:		State:	Zip Code:
Primary Language:		Secondary:	

## Requested Schedule

<input type="checkbox"/> Full days (six hours a day)
<input type="checkbox"/> Half days (three hours a day)
<input type="checkbox"/> Drop in

## Parent/Guardian Information

Name:	Relationship:
Primary Phone:	Secondary Phone:
Address:	
Email Address:	
Does the parent/ guardian have legal guardianship over the participant?	

## Caregiver Information (if different than parent/guardian)

Name:	Relationship:
Primary Phone:	Secondary Phone:
Address:	
Email Address:	

### Emergency Contact

Emergency Contact 1	Emergency Contact 2
Name:	Name:
Relationship:	Relationship:
Phone Number:	Phone Number:

### Applicant Medical Background

Primary Disability:
Additional Disabilities:
Medication Allergies:
Food Allergies:

### Applicant Medical Provider

Primary Physician Name:
Office Name:
Phone:
Address:

### Other Medical Providers

Name:	Name:
Specialty:	Specialty:
Phone:	Phone:
Name:	Name:
Specialty:	Specialty:
Phone:	Phone:

### Current Medications

Name of Medication	Reason for Medication		
Will the applicant need to take any of the above medications during program hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are they able to self-administer these medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Medical History

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> ADHD
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Partial Vision Loss	<input type="checkbox"/> Total Vision Loss	<input type="checkbox"/> Pica
<input type="checkbox"/> Partial Hearing Loss	<input type="checkbox"/> Total Hearing Loss	<input type="checkbox"/> Severe food allergy
<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Migraines
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other mental health
<input type="checkbox"/> Other:		

### Dietary Restrictions

<input type="checkbox"/> Dairy Free	<input type="checkbox"/> Gluten Free
<input type="checkbox"/> Low Sugar	<input type="checkbox"/> Sugar Free
<input type="checkbox"/> Other:	<input type="checkbox"/> None

### Adaptive Equipment

<input type="checkbox"/> Walker	<input type="checkbox"/> Wheel chair
<input type="checkbox"/> Cane	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> AAC or other talking device
<input type="checkbox"/> Other	<input type="checkbox"/> None

### Applicant previous education/training/employment

Primary School (K-8):
High School:
College:
Employment:
Other:

### Applicant Independence

Activity	Completes Independently	Needs some help and/or prompting	Needs significant help / can not do	Not Applicable
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage menstrual hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating/Drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow simple directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning up after self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep track of personal belongings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand basic safety rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Social Preferences (check all that apply)**

<input type="checkbox"/> Independent activities	<input type="checkbox"/> Partnered activities
<input type="checkbox"/> Small group activities (3-5)	<input type="checkbox"/> Large group activities (5+)
<input type="checkbox"/> Likes to initiate social interaction	<input type="checkbox"/> Likes others to initiate social interaction
<input type="checkbox"/> Prefers planned, facilitated activities	<input type="checkbox"/> Prefers self facilitating activities

**Behaviors (please check any behavior that has been shown within last 6 months)**

<input type="checkbox"/> Verbal outburst or aggression	<input type="checkbox"/> Noncompliance	<input type="checkbox"/> Use of bad language
<input type="checkbox"/> Physical aggression towards self	<input type="checkbox"/> Physical aggression towards others	<input type="checkbox"/> Stealing
<input type="checkbox"/> Property destruction	<input type="checkbox"/> Eloping	<input type="checkbox"/> None
<input type="checkbox"/> Other/:		
Behavior description/context:		

**Common Stressors/Triggers**

<input type="checkbox"/> Loud noises	<input type="checkbox"/> Change in routine	<input type="checkbox"/> Smells
<input type="checkbox"/> Substitute staff or new people	<input type="checkbox"/> Being touched unexpectedly	<input type="checkbox"/> Transitioning between activities or rooms
<input type="checkbox"/> Peer behavior	<input type="checkbox"/> Bright or flickering lights	<input type="checkbox"/> Unfamiliar environment
<input type="checkbox"/> Textures	<input type="checkbox"/> Crowded Spaces	<input type="checkbox"/> Waiting or delays
<input type="checkbox"/> Temperature	<input type="checkbox"/> Separation from caregiver	<input type="checkbox"/> None
<input type="checkbox"/> Other:		
Description/context of triggers		

### Self Regulation Behaviors

<input type="checkbox"/> Swinging	<input type="checkbox"/> Chewing	<input type="checkbox"/> Rocking	<input type="checkbox"/> Pacing
<input type="checkbox"/> Holding a preferred object	<input type="checkbox"/> Repeating words or phrases	<input type="checkbox"/> Requesting help	<input type="checkbox"/> Jumping or bouncing
<input type="checkbox"/> Counting	<input type="checkbox"/> Humming or singing	<input type="checkbox"/> Deep pressure	<input type="checkbox"/> None
<input type="checkbox"/> Other:			

### Incident History

Has the applicant ever been in trouble with the law? If so, please explain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<hr/> <hr/>		
Has the applicant ever been asked to leave or discharged from any previous program or service due to behavioral concerns or challenges? If so, please explain the circumstances		
<input type="checkbox"/> No <input type="checkbox"/> Yes		
<hr/> <hr/>		

### Applicant Interests

What are your job/vocational interests?
Are you involved in community activities? (such as volunteering, clubs, etc.)
What are your hobbies?
Favorite topics, characters, or themes?
Do you have any pets?
What is your favorite movie or show?

What is your favorite food?

Where are your favorite places to go?

What are your favorite games?

What makes you feel calm, happy, or safe?

What would you like us to know about you?

**Additional Likes & Dislikes**

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**Are you interested in participating in or learning about any of the following activities:**

<input type="checkbox"/> Exercise	<input type="checkbox"/> Yoga	<input type="checkbox"/> Walking
<input type="checkbox"/> Art	<input type="checkbox"/> Reading	<input type="checkbox"/> Dancing
<input type="checkbox"/> Singing	<input type="checkbox"/> Computer gaming	<input type="checkbox"/> Consol gaming
<input type="checkbox"/> Board games	<input type="checkbox"/> Cooking	<input type="checkbox"/> Gardening
<input type="checkbox"/> Sports	<input type="checkbox"/> Puzzles	<input type="checkbox"/> Building or constructing
<input type="checkbox"/> Media Literacy	<input type="checkbox"/> Sewing	<input type="checkbox"/> Animal Care
<input type="checkbox"/> Money skills	<input type="checkbox"/> None of these	<input type="checkbox"/> All of these
Other:		

**By signing below, you certify that all information provided in this application is complete, accurate, and truthful to the best of your knowledge. Any misrepresentation, omission, or falsification of information regarding the applicant’s abilities, behaviors, or needs may result in immediate termination from the program. Completion of this application does not guarantee acceptance into The Resting Tree program. All applicants will undergo a screening and interview process to determine eligibility for our services.**

Applicant printed name: \_\_\_\_\_

Guardian printed name: \_\_\_\_\_

Applicant/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only

Date Received:	Reviewed by:
Eligibility: <input type="checkbox"/> Eligible for interview <input type="checkbox"/> Not eligible for interview	Staff Notes: _____ _____