BAY SHORE SERVICES, INC.
SERVICE APPLICATION

APPLICANT INFORMATION		
Name:		
Address:		
City:	State:	ZIP Code:
Daytime Phone:	Cell Phone:	Email:
Date of birth:	SSN:	Sex:
Medicare #:	MA #:	Other Insurance:
Applicant Lives with: Parent(s) Other Relative Agency Foster Care School		
Primary Caregiver or Agency Name:		
Address (if different from above):		
City:	State:	Zip:
Daytime Phone:	Cell Phone:	Email:

GUARDIAN (as applicable)		
Legal Guardian Name:		
Address:		
City:	State:	Zip:
Phone:	Cell Phone:	Email:
Surrogate Decision Maker Name:		Relationship:
Address:		
City:	State:	Zip:
Phone:	Cell Phone:	Email:

EMPLOYMENT/DAY/SCHOOL INFORMATION		
Current Daytime Provider or Employer:		
Address:		How long?
Phone:	E-mail:	Fax:
City:	State:	ZIP:
Position:	Hourly Salary *(Please circle)*	Annual income:

EMERGENCY CONTACT		
Name:		Relationship:
Address:		Phone:
City:	State:	ZIP:
Phone:	Cell Phone:	Email:

FUNDING INFORMATION		
Funding Type: Day Residential CSLA Supports		
Other: Specify:		
Other: Specify:		
Waiver (specify):	Other (specify):	Other (specify):
Food Stamps: Yes No	Energy Assistance: Yes No	Housing Assistance: Yes No

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REPRESENTATIVE PAYEE INFORMATION

Name:		
Address:		How long?
City:	State:	Zip:
Phone:	Cell Phone:	Email:
SSI Amount $_____	SSDI Amount $_____	Pension Amount $_____
I understand that Bay Shore Services, Inc. becomes the representative payee for anyone who accepts residential services. Initial _____		

PREFERENCES/DISLIKES

State applicant's hobbies and interests:
State preferred activities:
State what the applicant dislikes:
State any fears or concerns:
State favorite TV shows or actors:
State favorite music or musicians:
State religious preference and frequency of attendance:
State any behavior concerns:
State the best approach for handling any behavior concerns:
Does applicant have a formal behavior plan? If yes, provide a copy.

Is the applicant social?	Like crowds?	Prefer quiet?
Like animals?	Smoke?	Like video games?
Use internet?	Like board games?	Read?

EATING HABITS (MARK ALL THAT APPLY)

Independent	Dependent	Preparation Assistance
Needs Feeding Assistance	Needs Special Utensils	Needs Supervision
Choking Risk	Other (specify)	Other (specify)

MOBILITY AND TRANSPORTION (MARK ALL THAT APPLY)

Does applicant need transportation? Yes No	Use: Walker Cane Wheelchair (specify): Motorize Manual
Walks: Independently Some Assistance One-person Assist Two-person Assist	
Uses Wheelchair: Never For Distances Frequently Always Other (specify)	
Climbs Steps/Curbs: Independent Some assistance Complete assistance	
Transfers: Independent Some Assistance Complete Assistance Two-Person Assist Hoyer Lift	

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Indicate any special accommodation required for mobility:

COMMUNICATION (MARK ALL THAT APPLY)	
Communicates in sentences	Uses sign language
Uses some words	Uses communication device
Does not use words	Uses gestures
Understands commands: All Most Some None	Other (specify):
How does the applicant express pain or illness?	

TOILETING		
Continent	Incontinent	Stress Incontinence
Nighttime Incontinence	Intermit Incontinence	Uses catheter
Colostomy	Frequent UTIs	
Use depends: Always Traveling Sleeping with UTIs		Other (specify):

HYGIENE (MARK 'I' FOR INDEPENDENT, 'D' FOR DEPENDENT OR 'S' FOR SUPERVISION		
Bathing	Shaving	Dressing
Hair care	Nail Care	Tooth Brushing
Menstrual Needs	Assist in/out of Tub	After toilet use
Hand/Face Washing	Other (specify)	Prefers: Shower Tubbath

SLEEP HABITS	
Does applicant have a bedtime? Yes No	What Time?
Does applicant take naps? Yes No	What time?
Does applicant sleep all night? Yes No	If no, state how often applicant wakes.
Is applicant at risk of eloping at night? Yes No	Is applicant at risk of hurt self or other if awake? Yes No
What precautions are needed during wakeful periods?	

MEDICAL INFORMATION	
Diagnosis:	
Height	Weight
Allergies – Food, Medication and Environmental	
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Latex Allergy Yes No	Bee Sting Yes No
Does applicant have an epée pen? Yes No	
Immunizations –	
Hepatitis B Vaccine:	Immunization date:
Tetanus:	Immunization date:

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PPD (TB testing): Positive Negative	Date:
Flu Shot:	Date:
Pneumonia Vaccine:	Date
Hepatitis B Carrier: Yes No Unknown	MRSA Carrier: Yes No
C-Diff Carrier: Yes No	

Medication Administration

Applicant requires assistance with medications: None Needs Prompting Full-assistance required

Applicant takes medications:

- Without difficult (give 8 ounces of water/fluid)
- Crushed
- With applesauce or soft food items
- Liquid form medications
- Liquid form medications with thick it
- G-tube only, nothing by mouth
- Other (specify) _____

Has applicant ever had a choking incident? Yes No If yes, state frequency

Has applicant ever had pneumonia? Yes No If yes, date of last occurrence:

Seizures

Does the applicant have seizures? Yes No	Are seizures longer than 5 minutes? Yes No

Describe Seizures: (mark all that apply)

- Unresponsive
- One side of arm or leg jerks
- Drooling
- Bluish facial color
- Stares off in space
- Feel light-headed
- Sleeps after seizure for _____ minutes
- Seizures last for _____ amount of time
- Other _____
- Other _____

State any procedures or mediations to be given for seizures:

List Adaptive Equipment (helmet, eating utensils, splints, AFO, Bi-pap, etc.

Equipment	**Time Used**

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General Health – Please check only what applies

- o Impaired ability to perform activities of daily living
- o Sleeps during the night
- o Has difficulty sleeping or falling asleep at night
- o Naps or sleeps during the day
- o Has old scars, bumps, lumps or skim breakdown
- o History of sinus infections
- o History of nose bleeds
- o Difficulty chewing or swallowing
- o Has dentures or bridge work
- o Scattered, missing or no teeth
- o Braces on teeth
- o Health teeth
- o History of eye problems
- o Uses corrective lens/glasses
- o Has contact lens
- o History of cataracts or glaucoma
- o Abnormal sensitive to noise
- o History of ear infections
- o Uses earring aid : Right ___ Left_____ Both_____
- o History of pneumonia or bronchitis
- o Breathing Difficulty
- o History of asthma, wheezing or breathing problems
- o Must sit up to breathe especially at night.
- o Swelling of ankles, feet, hands, or other body parts (specify) _____
- o Discoloration of hands, feet, fingers, toes or other body parts (specify) _____
- o History of stomach ulcers, vomiting blood
- o History of frequent vomiting
- o History of reflux, pain upon eating or nausea
- o History of eating disorders
- o Obesity
- o History of constipation or diarrhea (circle one or both)
- o Changes in bowel elimination patterns
- o History of hemorrhoids
- o Use laxatives, stool softeners
- o Use high fiber diet, prune juice, other natural fiber
- o Frequent urination
- o History of frequent urinary tract infections.
- o Bed-wetting or incontinence
- o Feces smearing
- o History of fainting or loss of consciousness
- o History of self-injurious behavior
- o Mood disorders
- o History of drug or alcohol dependence

Medical Care Dates - state the dates of the last appointments

Dental	Eye Exam
Physical	Gynecologist
Therapist	Psychiatrist

SIGNATURES

I authorize Bay Shore Services, Inc. to discuss my plan for services with members of my team and other services providers.

Signature of applicant:	Date:
Signature of Parent/Guardian:	Date:

Application can be mailed to: Bay Shore Services, Inc. , 1235 Pemberton Drive, Salisbury, MD 21801 or faxed 410-341-0308
Questions call: 410-341-0307