Chestnut Hill College

Life Skills Through Career Program

Adult Training Facility (2380) – Participant Application Packet

SECTION 1 — General Information

- **Full Name: _____**
- **Date of Birth:_____**
- **Gender: _____**
- **Address: _____**
- **Phone: _____**
- **Email: _____**
- **County of Residence: _____**
- **Emergency Contact Name: _____**
- **Relationship: _____**
- **Phone: _____**
- **Guardian/Power of Attorney (if applicable): _____**
- **Phone/Email: _____**

SECTION 2 — Diagnostic and Eligibility Information

- **Primary Diagnosis: _____**
- **Secondary Diagnoses: _____**
- **Date(s) of Diagnosis: _____**
- **Diagnosing Professional/Agency: _____**

- **Attach supporting documentation:** ☐ Psychological Evaluation ☐ Neuropsychological Evaluation ☐ IEP/ISP Summary ☐ Medical/Behavioral Reports
- **Functional Limitations:** (Check all that apply)
  ☐ Communication ☐ Self-Care ☐ Mobility ☐ Socialization ☐ Learning ☐ Independent Living

SECTION 3 — Educational and Vocational History

- **Highest Level of Education Completed: _____**
- **Schools/Programs Attended:**
  _____
- **Graduation/Completion Date: _____**
- **Previous Day or Vocational Programs Attended:**
  _____
- **Employment History:**
  - Employer: _____
  - Job Title: _____
  - Dates of Employment: _____
  - Reason for Leaving: _____
- **Job Skills or Interests:**
  _____
- **Current Vocational Goals:**
  _____

SECTION 4 — ISP and Waiver Information

- **Do you have a current Individual Support Plan (ISP)?** ☐ Yes ☐ No
- **If yes, Service Coordinator Name:**
  _____

- **Agency: _____**
- **Phone/Email: _____**
- **List current goals and outcomes relevant to day program participation:**

- **Are you approved for state waiver funding?** ☐ Yes ☐ No
  - **Type of Waiver:** ☐ Consolidated ☐ Community Living ☐ P/FDS ☐ Other: _____
  - **Supports Coordinator Contact:** _____
- **HCSIS # or Master Client Index (MCI) # (if applicable):** _____

SECTION 5 — Medical and Health Information

- **Primary Care Physician: _____**
- **Phone: _____**
- **Health Insurance Provider: _____**
- **Policy #: _____**
- **Date of Last Physical Exam: _____** (Must be within 12 months per §2380.111)
- **Allergies (food, medication, environmental):** _____
- **Medications (include dosage and schedule):** _____
- **Special Dietary Needs: _____**
- **Seizure History:** ☐ Yes ☐ No — If yes, describe: _____
- **Mobility/Assistive Devices: _____**
- **Emergency Medical Orders:** (EpiPen, seizure protocol, oxygen, etc.) _____

- **Preferred Hospital: _____**

SECTION 6 — Behavioral and Support Needs

- **Behavior Support Plan in place?** ☐ Yes ☐ No
- **If yes, attach current BSP and indicate target behaviors:** _____
- **1:1 or staff ratio required:** ☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4
- **Triggers or calming strategies: _____**
- **Communication methods:** ☐ Verbal ☐ AAC ☐ ASL ☐ Device (type: _____)

SECTION 7 — Transportation and Daily Logistics

- **Transportation to program provided by:**
  ☐ Family ☐ County Transportation ☐ Provider Agency ☐ Self ☐ Other: _____
- **Arrival Time: _____ Departure Time: _____**
- **Pick-up/Drop-off Contact Name:** _____
- **Phone: _____**

SECTION 8 — Personal Statement (to be completed by applicant)

"In your own words (or with assistance), please tell us about yourself — your interests, goals, and what you hope to achieve in the Life Skills Through Career Program."

(Signature of Applicant) _____ Date: _____

SECTION 9 — Required Attachments Checklist

- ☐ Copy of Psychological Evaluation (within 3 years)
- ☐ Copy of Physical Exam (within 12 months)
- ☐ Immunization Record
- ☐ Medication List (if applicable)
- ☐ Behavior Support Plan (if applicable)
- ☐ Current ISP and Goals
- ☐ Proof of Insurance and ID
- ☐ Waiver Approval Letter (if applicable)

☐ Guardianship/POA Documentation (if applicable)
☐ Emergency Medical Orders
☐ Transportation Plan
☐ Photo Release Form
☐ Consent to Share Information

SECTION 10 — Provider Review and Acceptance

- **Date Application Received: _____**
- **Reviewed By (Program Specialist): _____**
- **Meets Admission Criteria:** ☐ Yes ☐ No
- **Additional Information Requested: _____**
- **Interview/Intake Date: _____**
- **Accepted for Admission:** ☐ Yes ☐ No
- **Start Date: _____**
- **Assigned Staff/Case Manager: _____**
- **Notes/Comments: _____**