STEPHENS BRAIN INJURY CAMPUS APPLICATION
GREELEY CENTER FOR INDEPENDENCE, INC.

APPLICANT INFORMATION

Applicant's Name:_____Nickname**:**_____
Applicant's Social Security Number:_____ Date of Birth**:**_____
Current Address:_____
City:_____State:_____Zip:_____ Phone#_____
Sex: M F Height:_____ Weight:_____ Hair:_____ Eyes:_____
Primary Language:_____ Competent English Speaker Yes___No___
Diagnosis:_____Date of onset of brain injury:_____
Explain how brain injury was acquired:_____
_____
Other Medical/Health Concerns:_____
Name of person filling out form:_____Relationship:_____

FAMILY AND RESPONSIBLE PARTIES INFORMATION

Nearest Relative:_____ Relationship:_____
Address:_____
City:_____State:_____Zip:_____
Phone# (Home):_____ Phone#(Work):_____
Do you have a Guardian? Yes_____ No _____ If Yes, Who?
Name:_____
Phone# (Home):_____ Phone#(Work):_____
Do you have a Conservator? Yes_____ No_____ If Yes, Who?
Name:_____
Phone# (Home):_____ Phone#(Work):_____
Do you have a Durable Power of Attorney? Yes_____ No_____ If Yes, Who?
Name:_____
Phone# (Home):_____ Phone#(Work):_____
(Must provide copy of document designating guardian, conservator, Durable Power of Attorney).

PREINJURY STATUS

Level of Education:_____Job Status:_____
Alcohol or drug abuse history:_____
Had you received treatment for alcohol and/or drug abuse? Yes____ No____
If Yes, where and when_____
Marital Status:_____
Any Children: Yes____ No____
Living Situation:_____
Had you been arrested:Yes____No____
Alleged Offense:_____Date:_____Outcome:_____
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POSTINJURY STATUS

MEDICAL

Do you require assistance with medications? Yes___ No____
Have you had or do you experience seizures? Yes___ No____
If Yes, are they controlled by medications? Yes____ No____
What is the date of your last seizure? _____
Do you see normally with both eyes? Yes___ No____
If No, please explain_____
Do you hear normally? Yes____ No____
If No, please explain_____
Do you have trouble controlling your bladder? Yes____ No____
If Yes, please explain_____
Do you have trouble controlling your bowels? Yes____ No____
If Yes, please explain_____
Do you have any eating/swallowing concerns? Yes____ No____
If Yes, please explain_____
Do you have problems affecting speech? Yes____ No____
If Yes, please explain_____
Do you have pain? Yes____ No____
If Yes, please explain_____
Do you smoke? Yes____ No____
If Yes, please explain_____
Do you drink alcoholic beverages? Yes____ No____
If Yes, how much and how often?_____
Other medical concerns or special health needs:_____
_____

MOBILITY

Circle any of the following that you currently use:
power wheelchair, manual wheelchair, walker, cane, crutches, other_____
Do you need assistance with the use of the above? Yes____ No____
If Yes, please explain_____
Do you have problems with your balance? Yes____ No____
If Yes, please explain_____
_____
Can you go up and down stairs safely and independently? Yes____ No____
Do you need assistance with the following:
Getting in and out of bed Yes____ No____
Getting in and out of the shower Yes____ No____
Getting on and off the toilet Yes____ No____
Getting up or sitting down in a chair Yes____ No____

COGNITION

Do you have problems with the following?

Memory	Yes____ No____
Orientation to time, person or place	Yes____ No____
Confusion	Yes____ No____
Planning	Yes____ No____
Organization	Yes____ No____
Judgement	Yes____ No____
Initiating activities	Yes____ No____

Other (please specify)_____

EMOTIONAL AND BEHAVIORAL ADJUSTMENT

Do you have problems with:

Depression	Yes____ No____
Thoughts of suicide	Yes____ No____
Paranoia	Yes____ No____
Controlling your actions sexually	Yes____ No____
Alcohol or drugs	Yes____ No____

Do you get angry easily? Yes____ No____

If yes what causes this?_____

What are the best ways to help you calm down?_____

_____

How would you rate your frustration tolerance?(check below)

Never frustrated_____ Sometimes frustrated_____ Always frustrated_____

What causes you to become frustrated?_____

_____

Do you ever verbally lose control?	Yes____ No____
Do you ever physically lose control?	Yes____ No____

When angry or under stress, do you:

Swear at others	Yes____ No____
Threaten others	Yes____ No____
Hit, push, or physically attack others	Yes____ No____
Throw or break things	Yes____ No____
Do nothing	Yes____ No____
Run away	Yes____ No____

Other _____

EMOTIONAL AND BEHAVIORAL ADJUSTMENT

What time do you normally go to bed?_____
What time do you normally get up in the morning?_____
Do you get up at night? Yes____ No____
If yes, are you oriented to where you are.
Describe your mood if you get up at night. _____
_____
Are you currently receiving psychotherapies or psychiatric treatment? Yes____ No____
If Yes please explain the focus of treatment?_____
_____
Name of person providing treatment and phone number:
Name:_____ Phone#_____

ACTIVITIES OF DAILY LIVING SKILLS

Check level of assistance required for each task	**Independent**	**Cues or Supervision**	**Physical Assistance**
Bathing			
Dressing			
Brushing Teeth or Cleaning Dentures			
Brushing and/or styling hair			
Shaving			
Feeding self			
Cooking			
Laundry			
Cleaning room/apartment			
Reading			
Writing			
Using Telephone			

Do you drive? Yes____ No____

What are your hobbies:_____
_____

MEDICATION SHEET

What allergies do you have?_____
_____

Medications (mg, times per day)	**Taken For**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____

If there are more than 15 medications put them on the back of this form.

FINANCIAL INFORMATION

Do you manage your own money? Yes_____ No_____
Representative Payee:_____
Please list the source of your income and amount:

( ) Social Security	Amount_____
( ) SSI	Amount_____
( ) SSDI	Amount_____
( ) Pension	Amount_____
( ) Alimony	Amount_____
( ) Disability Insurance	Amount_____
( ) Other	Amount_____

What type of insurance do you have? (Enclose copy of front & back of insurance cards)

Policy #_____ ID#_____

Company_____ Contact_____

Address_____ Phone(_____

Policy #_____ ID#_____

Company_____ Contact_____

Address_____ Phone(_____

Do you have Medicaid? Yes____ No____ If yes, Medicaid#_____State_____

Do you have Home and Community Based Services (HCBS)? Yes____No____

If yes, in what county?_____ Phone#_____

Who is your HCBS Case Manager?_____

Do you have Medicare? Yes___ No___ Part A____ Part B____

If yes, what is your Medicare#?_____

OTHER INFORMATION NEEDED WITH APPLICATION

1. Physicians History, Current Physical, Neuropsychological evaluation if available.

2. If receiving psychological services, a letter from the person providing services. It should explain the psychological condition of applicant, any concerns the therapist has, and the therapist's recommendation regarding your participation in this program.

Please return to:

Stephens Brain Injury Campus
2774 Reservoir Road
Greeley, CO. 80634

If you have any questions please call Jenn Palmer, Director of Brain Injury Services at 970-506-0008.

Volunteer Survey

Government agencies at times require periodic reports on the gender, ethnicity, veteran and other protected status of applicants. This data is for statistical analysis only. **Submission of this information is voluntary and in no way affects the application process.**
Check one: □ Male □Female
Are you a veteran of the U.S. Armed Services? □ Yes □ No
Ethnicity/Race: (check only one) □ Black or African American, Not Hispanic or Latino □ American Indian or Alaska Native, Not Hispanic or Latino □ Asian, Not Hispanic or Latino □ Native Hawaiian or other Pacific Islander, Not Hispanic or Latino □ Hispanic or Latino □White, Not Hispanic or Latino