



P.O. Box 948, Walworth, WI 53184-0948
262.275.5753 • www.inspirationministries.org

Enrollment Application

Applying for (check box):

- Residency at Inspiration Ministries (complete Financial Worksheet)
- Flexible Respite Care Program
- Summer Respite Care Camp Fall, Winter, Spring Respite Care Camp

Please answer all questions regarding the applicant as completely as possible (applicant refers to the person for whom enrollment is being sought). All information is considered confidential.

Date of Application: _____

Applicant Name: _____ Nickname: _____

Address: _____

City, State, Zip: _____

Day Phone: (_____) _____ Evening Phone: (_____) _____

Gender: Male Female Age: _____ Date of Birth: _____

Marital Status: Single Married Widowed Divorced

Group Home? Yes No If yes, name of group/foster home: _____

Caregiver Name: _____ Cell Phone: (_____) _____

E-mail: Yes No If yes, provide: _____

Name of Physician: _____ Phone: (_____) _____

Name of Pharmacy: _____ Phone: (_____) _____

Name of Dentist: _____ Phone: (_____) _____

BENEFITS/INSURANCE INFORMATION:

Social Security #: _____ Medical Assistance #: _____

Medicaid/Title 19 #: _____

Medicare: Part A effective date: _____ Part B effective date: _____

Part C (Medicare Advantage): _____ Part D Name and #: _____

VA #: _____ RR #: _____

Waiver What State/County: _____

Private/Other: Carrier/ID#: _____

FAMILY INFORMATION (living family members):

Father's Name _____ Mother's Name _____

Address, if different: _____

City, State, Zip: _____ Phone: (_____) _____

RELIGIOUS TRADITION (if applicable): N/A

Denomination (i.e., Baptist, Catholic, Lutheran, etc.) _____

Church Name: _____

Address, City, State, Zip: _____

Pastor's Name: _____

For emergency purposes, ALL guests MUST complete this section. Guests are responsible for all medical bills incurred during their stay at Inspiration Ministries.

ADVANCE DIRECTIVES:

Does the applicant have advance directives? Yes No If yes, please attach a copy of document.

Living Will Durable Power of Attorney Do Not Resuscitate Orders

EMERGENCY CONTACT INFORMATION:

First Emergency Contact:

Second Emergency Contact:

Name: _____

Address: _____

City, State, Zip: _____

Phone (H): _____

Phone (W): _____

Phone (C): _____

Relationship: _____

LEGAL GUARDIANSHIP:

Self? Court-appointed guardian?

If court-appointed, who? _____ Person? Estate?

If the guardian is not the applicant's parent, please complete the following:

Address, City, State, Zip: _____

Phone (H): _____ Phone (W): _____

Relationship to Applicant: _____

MEDICAL HISTORY:

What is applicant's medical diagnosis? _____

Primary Disability: _____ Secondary Disability: _____

Is the applicant diabetic? Yes No If yes, normal blood sugar range _____

Is the applicant insulin dependent? Yes No Are they on a sliding scale? Yes No

Seizure disorder? Yes No Date of last seizure: _____

Nature, severity, and frequency of seizures: _____

Precipitating factors: _____

COGNITIVE ABILITY: (check one)

- Normal function Mild impairment Moderate impairment Severe impairment

MOBILITY: (check all that apply)

Can the camper walk? Yes No If yes: Unaided With assistance

Walking speed: Slow Medium Fast

Aides: Crutches Walker Cane Braces Wheelchair Power wheelchair?

Scooter? Yes No Is a wheelchair needed for long distances? Yes No

If the applicant uses a wheelchair, can he/she propel him/herself? Yes No

Can applicant support his/her own weight for transfer? Yes No Height: _____ Weight: _____

SPEECH/COMMUNICATION:

Verbal Non-verbal Able to read? Yes No Able to write? Yes No

Does applicant have a hearing impairment? Yes No Wears a hearing aid? Yes No

Uses sign language? Yes No List any commonly used signs or gestures: _____

Language device used? Yes No If yes, describe: _____

Does applicant have a vision impairment? Yes No Wears glasses/contacts? Yes No

BEHAVIOR/SOCIAL:

Please check the following (all that apply) that generally describe applicant:

- | | | | |
|---------------------------------------------------|------------------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Enjoys being with other | <input type="checkbox"/> Prefers being alone | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Easy going/cheerful | <input type="checkbox"/> Shy/withdrawn | <input type="checkbox"/> Immature | <input type="checkbox"/> Worries |
| <input type="checkbox"/> Unsure of new situations | <input type="checkbox"/> Sensitive/Moody | <input type="checkbox"/> Depressed | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Verbally aggressive | <input type="checkbox"/> Physically aggressive | <input type="checkbox"/> Demanding | <input type="checkbox"/> Wanders |

PERSONAL CARE: (check appropriate boxes)

Level of assistance needed:	Total	Some	Supervise	Verbal Prompts	None
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing teeth/dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual care (women)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating skills/feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BLADDER/BOWEL CONTROL:

- Bladder: Communicates need Needs a reminder On a schedule
Catheter: Yes No Assistance needed? Yes No
Bowel: Communicates need Needs a reminder On a schedule
Wears Depends: All day Only for long trips Only at night/bedtime

ASSISTIVE EQUIPMENT:

- Toilet: Grab bar Yes No Shower chair needed? Yes No
Hospital bed needed? Yes No Bed height level with wheelchair? Yes No

- SLEEP PATTERNS: Normal Abnormal (explain) _____
Regular bedtime? _____ Wets bed? Yes No
Does applicant use oxygen/CPAP machine at night? Yes No Needs assistance? Yes No

ACTIVITIES:

- Swimming: Independent Uses life vest Cannot swim Fears water
Bowling: Likes Dislikes Requires ramp
Restrictions (explain): _____

DIET:

- Regular-no restrictions May applicant have second helpings? Yes No
 Restrictions/special diet (explain): _____
Is applicant allergic to any foods? Yes No If yes, list: _____
Does applicant require any assistive eating devices? Yes No If yes, list: _____
Assistance cutting food? Yes No Ground diet? Yes No Puréed diet? Yes No
Other comments: _____

