LSE Program Services Application

Have you been determined DDA eligible? _____ Yes _____ No

DDA Waiver Approved? _____ Yes _____ No

Services Requested:

_____ Day Habilitation _____Employment Services

_____ Community Development Services _____Career Exploration: Facility-based

*LSE is no longer a Sheltered Workshop

Demographic Information:

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cellphone: _____

DOB: _____ Sex: _____ SS#: _____

Primary Disability: _____

Secondary Disability: _____

During High School:

1. Did the individual receive 1:1 support? _____ Yes _____ No

If yes, what was the purpose of the support? _____

2. Was the individual in a self-contained or general education classroom?

_____

Who does the individual live with:
_____Parents _____Mother _____ Father _____Relative _____ Agency _____ Self
_____Other

Primary Caregiver's Name: _____ Phone: _____
Email address: _____

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If there is a legal guardian please provide the information below and attach guardianship paperwork:

Legal guardian name: _____ Phone: _____

Address: _____
(if different from above) (Street) (City) (State) (Zip)

Email Address: _____

Emergency Contacts:
Name: _____ Address: _____

Phone: _____ Cell: _____ Relationship: _____

Name: _____ Address: _____

Phone: _____ Cell: _____ Relationship: _____

Other agencies involved with individual:

Name of program	Contact Person	Phone
_____	_____	_____
_____	_____	_____

Transportation:
Is transportation needed for this individual: _____ yes _____ no

Can individual use public transportation: _____ yes _____ no

Does the individual use a wheelchair: _____ yes _____ no

Special accommodations: _____

Employment:
Is the individual currently employed? _____Yes _____ No

If yes, where? _____

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If No, Are you interested in Community Employment? _____ Yes _____ No

Communication: (check all that apply)

_____ communicates in full sentences
_____ follows simple verbal commands
_____ uses a communication device
_____ uses sign language
_____ able to follow simple written directions

Describe any assistance needed: _____

Eating Habits:

_____ Independent
_____ requires assistance with set up/heating meals

Describe any assistance needed: _____

Toileting: (check all that apply)

_____ Independent
_____ periodic incontinence
_____ requires prompting – hygiene
_____ requires full assistance
_____ Continent
_____ requires reminders or toileting schedule
_____ requires assistance with transfers
_____ uses adult incontinence pads or underwear

If a toileting accident happens, what assistance is needed?

_____

Mobility:

_____ walks independently
_____ uses walker
_____ needs assistance with transfers
_____ uses a wheelchair at all times
_____ uses cane
_____ needs assistance when walking
_____ uses wheelchair at times
_____ uses a scooter

Describe any assistance needed: _____

Personality:

Is the Individual social? _____
Does he/she smoke or use drugs? _____
Are there any strong fears we should be aware of? _____
Please describe the individual's personality traits: _____
_____

Is there a current Behavior Plan? _____ if yes, must be attached for consideration in the program

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Has the individual had a Behavior Plan in the last 3 years? _____ if yes, must be attached for consideration into the program

If there is no Behavior Plan please answer the following questions:

1. Is there any negative behavior that staff should be aware of?
   _____
2. If yes, what strategies are effective in helping the individual with this behavior?
   _____

Health/Medical information:
Other Medical Diagnosis:
_____

Food or Medication Allergies:
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Current Weight: _____lbs Special Diet: _____

Medication Administration:
_____ Self-Administers _____ Needs prompting _____ Cannot self medicate

Current Medications: Please list or attach PMOF
Name: _____ Dosage: _____ Frequency:_____
Reason for medication: _____

Name: _____ Dosage: _____ Frequency:_____
Reason for medication: _____

Any history of seizures? _____ Do seizures last longer than 5 minutes? _____
Describe seizures: _____

Adaptive Equipment
(helmet, splints, Communication devices, AFO) When Used

_____ _____

_____ _____

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General Health – please check all that apply

- Any old scars, bumps or lumps
- History of Sinus Infections
- History of nose bleeds
- Difficulty chewing or swallowing
- Use of dentures or bridges
- History of eye problems
- Use of corrective lenses (glasses)
- Uses of contact lenses
- History of cataracts or glaucoma
- Abnormal sensitivity to light
- Abnormal sensitivity to sound
- History of ear infections
- Uses hearing aid _____ Lt _____ Rt
- History of pneumonia or bronchitis
- Difficulty breathing (asthma, COPD, wheezing)
- History of stomach ulcers, vomiting blood
- History of Reflux
- History of constipation or diarrhea
- History of urinary tract infections
- Incontinence
- History of fainting or loss of consciousness
- History of cognitive disturbances (memory loss, hallucinations, disorientation)
- History of speech or language dysfunction
- History of fractures
- Spinal deformity
- Chronic back problems
- History of anemia
- History of easy bruising
- Any open sores, wounds or rashes on body
- Heat or cold intolerance

Other pertinent information:

_____

_____

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Signature Section

Signature of applicant: _____ Date: _____

Signature of person completing form: _____ Date: _____

Signature of legal guardian: _____ Date: _____

Applications are reviewed by the LSE Admissions Committee monthly.

Applications can be mailed to:
28475 Owens Branch Rd.
Salisbury, MD 21801
Attn: Crystal Chatham
or
Emailed to:
cchatham@lseworks.org