Melmark *New England*
461 River Road
Andover, MA 01810

978 654 4300
Fax 978 654 4315
www.melmarkne.org

ADMISSIONS APPLICATION

In order to facilitate review and processing, please complete all information requested.
If not applicable, please state "*N/A*" or "*Unknown*" where applicable. **Please type or print.**

General Information

Applicant Name: _____ Date: _____
Last *First* *M.I.*

☐ Natural Born ☐ Adopted ☐ Male ☐ Female

Primary Diagnosis: _____ Secondary Diagnosis: _____

Date of Birth: _____ Social Security No.: _____ SSI No: _____

Present Height: _____ Present Weight: _____ Eye Color: _____ Hair Color: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Country: _____

Referral for: ☐ Early Childhood (Day School, ages 3-10) ☐ School Age (Day School, ages 11-22) ☐ Residential
(Please note that typically Melmark *New England* does not admit after 16 years of age)

Mother's Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Work Phone: _____ E-mail Address: _____

Father's Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Work Phone: _____ E-mail Address: _____

Closest Relative: _____ Relationship: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Work Phone: _____ E-mail Address: _____

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Who referred you to Melmark *New England*? _____

Court-Appointed Legal Guardian

Name: _____ Relationship: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Work Phone: _____ E-mail Address: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Work Phone: _____ E-mail Address: _____

Please attach a recent
(taken within the past year)
photo of applicant here

Name of Person Completing Application: _____

Signature of Person Completing Application: _____

Relationship to Applicant: _____ Date: _____

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General Family Background Information

MOTHER: _____ Age: _____
Last *First* *Maiden Name*

Date of Birth: _____ U.S. Citizen? YES ☐ NO ☐ Social Security No.: _____ Education: _____

Employer: _____ Occupation: _____

Employer Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Single

FATHER: _____ Age: _____
Last *First*

Date of Birth: _____ U.S. Citizen? YES ☐ NO ☐ Social Security No.: _____ Education: _____

Employer: _____ Occupation: _____

Employer Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Single

SIBLINGS:

1. _____ DOB _____ 4. _____ DOB _____
2. _____ DOB _____ 5. _____ DOB _____
3. _____ DOB _____ 6. _____ DOB _____

OTHERS IN HOUSEHOLD:

1. _____ DOB _____ Relationship to Applicant: _____
2. _____ DOB _____ Relationship to Applicant: _____
3. _____ DOB _____ Relationship to Applicant: _____

Are any of the above persons mentally retarded or emotionally disturbed? YES ☐ NO ☐ If so, please describe briefly:

_____

_____

Birth and Developmental History

Date of Birth: _____ Birth Weight: _____

Place of Birth: (Hospital) _____ Location of Birthplace: _____
City *State*

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Duration of Pregnancy: _____ Duration of Labor: _____

Full term or Premature *Number of Hours*

Nature of Delivery: _____ If Applicant was adopted, at what age? _____

Natural, Breech, Cesarean, Forceps

Condition of Applicant at birth: _____

Development

Age when Applicant: Sat _____ Crawled _____ Walked _____

Talked _____ (Words) _____ (Phrases) _____

Toilet Training: Began _____ When completed? _____

Has Applicant been excessively active? YES ☐ NO ☐ _____

Does Applicant seem poorly coordinated or awkward? YES ☐ NO ☐ _____

***IMPORTANT**: Birth records from the hospital should be mailed to Melmark New England if the Applicant is accepted.*

Lifetime Medical History

Attach additional page(s) if necessary. Please include typed reports regarding past surgical procedures, therapies, hospital placements, medications, etc..

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Medical Information

Please note that complete records will be requested upon admission.

Diagnosis: _____

Allergies: _____ Reactions: _____

Please note that complete records and testing for allergies will be requested and reviewed prior to admission.

Summary of Current Health Problems: _____

_____

Primary
Physician's Name: _____ Specialty: _____

Address: _____

Street Address *Suite*

_____

City *State* *ZIP Code*

Phone: _____ Fax: _____ When was Applicant's last appointment with physician? _____

Immunizations

	Date		*Date*
DPT Initial Series		Chest X-Ray	
DPT Boosters		Mumps	
DPT or Tetanus Booster		Polio (Salk/Sabin) Initial Series	
Smallpox		Boosters	
Measles		Hepatitis Vaccine Series	
Rubella (German Measles)		Pneumovax	
TB Skin Test		H-Flu	

Illnesses

	YES	NO	*Date*		YES	NO	*Date*
Chicken Pox	☐	☐		Ear Infections	☐	☐	
Measles	☐	☐		Pneumonia	☐	☐	
Mumps	☐	☐		German Measles	☐	☐	
Diabetes	☐	☐		Whooping Cough	☐	☐	
Cardiac Defect	☐	☐		Scarlet Fever	☐	☐	
Kidney/Bladder Infections	☐	☐		Hepatitis	☐	☐	

Please list any diseases, disorders, or neurological or congenital defects such as Sickle Cell Anemia, Tay-Sachs, Tuberculosis, etc. which tend to occur in members of Applicant's family (blood relative).

_____

Past Surgical & Medical History

Illness/Surgery	*Date*	*Hospital*

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Present Medications

If the Applicant is receiving any medication at the present time, please list name of drug, dosage, date started, purpose and any adverse reactions to the drug. (Please include oral and topical medications.)

1. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Reaction: _____
2. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Reaction: _____
3. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Reaction: _____
4. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Reaction: _____

Past Medications

If the Applicant has received any other medication in the past, please list name of drug, dosage, date started, purpose, date discontinued and reason(s) for discontinuing.

1. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Date Discontinued: _____
   Reason(s) for Discontinuing: _____
2. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Date Discontinued: _____
   Reason(s) for Discontinuing: _____
3. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Date Discontinued: _____
   Reason(s) for Discontinuing: _____
4. Drug: _____ Dosage: _____ Date Started: _____
   Purpose: _____ Date Discontinued: _____
   Reason(s) for Discontinuing: _____

Important Information for Parents of Residential Students

1. Upon placement at Melmark *New England*, your child's current medication regime will be overseen by Melmark *New England*'s consulting Psychiatrist.
2. If you consider medication options in the future, you will be required to meet with Melmark *New England*'s consulting Psychiatrist.
3. Medication changes (not including seizure medications) that occur independent of Melmark *New England*'s consulting Psychiatrist and may be clinically counterproductive and Melmark *New England* reserves the right to make placement decisions based on these changes.
4. You will be required to sign a medication consent prior to your child's admission and yearly thereafter.

Important Information for Parents of Day (School) Students

1. If your child is currently receiving medication, it is imperative that you are accurate in identifying the medication and the dosage prior to the admission.
2. Upon admission, you must again identify the exact medication and the dosage that your child is receiving.
3. Whenever there is a change of medication, nursing personnel must be notified 24 hours prior to the change.
4. Changes that occur without notification to Melmark *New England* put the student at risk and Melmark *New England* reserves the right to make placement decisions based on changes.
5. You will be required to sign a medication consent prior to your child's admission and yearly thereafter.

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Review of Current/Past Health Problems

NEUROLOGICAL

Is there a history of seizures? YES ☐ NO ☐ Age of Onset: _____ Frequency: _____ Duration: _____

Occurrence with or without fever? _____ Date of Last Incidence: _____

Describe (in detail) seizure activity: _____

Date of last EEG: _____ CT Scan: _____ MRI: _____

Note: If hospital admission was required, please indicate under "Past Surgical & Medical History" on page 5.

Physician's Name _____ Email: _____

Address: _____

Street Address *Suite*

_____

City *State* *ZIP Code*

Phone: _____ Fax: _____ When was Applicant's last appointment with physician? _____

EYES

Visual Impairments: _____ Eye Infections: _____

Use of glasses? YES ☐ NO ☐ Purpose: _____ How often are glasses worn? _____

Eye Physician's Name: _____ When was Applicant's last appointment with physician? _____

Address: _____

Street Address *Suite*

_____

City *State* *ZIP Code*

EARS, NOSE & THROAT

Hearing Impairments: _____ Ear Infections: _____

Use of hearing aid? YES ☐ NO ☐ Type(s): _____

Physician's Name: _____ When was Applicant's last appointment with physician? _____

Address: _____

Street Address *Suite*

_____

City *State* *ZIP Code*

DENTAL

Dentist's Name: _____ Date of last dental exam: _____

Address: _____

Street Address *Suite*

_____

City *State* *ZIP Code*

Phone: _____ Fax: _____

Condition of Teeth: _____

Note: If surgery was required, please indicate under "Past Surgical & Medical History" on page 5.

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OTHER SPECIALTIES (Cardiology, gastroenterology, endocrinology, urology, gynecology, orthopedics, etc.)

1. Physician's Name: _____ Phone Number: _____ Email: _____
   Address: _____
   Street Address *Suite*
   _____
   City *State* *ZIP Code*
   Hospital Affiliation: _____ Reason for Evaluation: _____

2. Physician's Name: _____ Phone Number: _____ Email: _____
   Address: _____
   Street Address *Suite*
   _____
   City *State* *ZIP Code*
   Hospital Affiliation: _____ Reason for Evaluation: _____

3. Physician's Name: _____ Phone Number: _____ Email: _____
   Address: _____
   Street Address *Suite*
   _____
   City *State* *ZIP Code*
   Hospital Affiliation: _____ Reason for Evaluation: _____

THERAPIES (speech therapy, physical therapy, occupational therapy)

1. *Type of Therapy* _____ *Frequency* _____ *Approximate Start Date* _____ *School or Home?* _____
   Therapist's Name: _____ Phone Number: _____

2. *Type of Therapy* _____ *Frequency* _____ *Approximate Start Date* _____ *School or Home?* _____
   Therapist's Name: _____ Phone Number: _____

3. *Type of Therapy* _____ *Frequency* _____ *Approximate Start Date* _____ *School or Home?* _____
   Therapist's Name: _____ Phone Number: _____

MISCELLANEOUS

Menstrual Pattern: _____ Age of Onset: _____ Regular? ☐ YES ☐ NO Difficulty with flow or cramping? ☐ YES ☐ NO

Bowel Pattern: _____ Frequency of bowel movements: _____ History of constipation? ☐ YES ☐ NO

PROSTHESIS/ORTHOPEDIC DEVICES *(Please list below any appliances and how worn)*

_____

_____

_____

_____

_____

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Insurance Coverage

Is the Applicant covered by the insurance listed below? YES ☐ NO ☐

Subscriber's Name: _____ Social Security Number: _____

Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Name of Insurance Company (Primary Carrier): _____

Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Type of Coverage: _____ Policy Number: _____

Name of Insurance Company (Secondary Carrier): _____

Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Type of Coverage: _____ Policy Number:

Blue Cross/ Blue Shield YES ☐ NO ☐ Plan: _____ Policy Number: _____

Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Medicaid/Medicare YES ☐ NO ☐ Name: _____ Number: _____

State ID Number: _____ Date: _____

Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Name of Dental Insurance Company: _____

Address: _____
Street Address *Suite*

_____
City *State* *ZIP Code*

Type of Coverage: _____ Policy Number:

Billing forms for any or all of the above may be obtained from:

_____

_____

_____

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Personal History

Please state what you consider to be the Applicant's strengths: _____

List specific problems/behavior presented by the Applicant: _____

What, if anything, about the Applicant's behavior is troublesome for family, friends or community? _____

When were these problems first noted? _____ How frequently? _____

When the applicant exhibits these problems, does he/she respond to:

Verbal cues? YES ☐ NO ☐ Directives? YES ☐ NO ☐ Physical assistance? YES ☐ NO ☐

Was the result: Successful? YES ☐ NO ☐ Or Unsuccessful? YES ☐ NO ☐

Describe the Applicant's awareness of and response to danger, including whether verbal or physical assistance is necessary:

What events or behavior brought about your request for enrollment? _____

Is the Applicant residing at home? YES ☐ NO ☐

Please describe briefly your goals and expectations for the Applicant and what you hope Melmark *New England* will accomplish:

Language(s) spoken in Applicant's home: _____ Religion: _____

COMMENTS

(*Please use the space below or the back of this sheet for additional information or comments concerning the Applicant's personal history*)

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Recreational Activities

The following is a guide list of activities in which the Applicant may have an interest.
Please indicate with an asterisk (*) wherever appropriate.

Skating (in-line)	_____	Coloring	_____	Television	_____	Musical Instruments	_____
Baseball	_____	Drawing	_____	Radio	_____	Cooking	_____
Basketball	_____	Building Toys	_____	DVD movies	_____	Fishing	_____
Football	_____	Dolls	_____	CD music	_____	Camping	_____
Soccer	_____	Cars, Trucks	_____	Stories	_____	Hiking	_____
Bowling	_____	Models	_____	Reading	_____	Sledding	_____
Tennis	_____	Table games	_____	Singing	_____	Air Hockey	_____
Swimming	_____	Crafts	_____	Social Dancing	_____	Puzzles	_____
Bike Riding	_____	Stamps	_____	Square Dancing	_____	Video games	_____

Others: _____

SWIMMING SKILLS

Good: _____ Fair: _____ Poor: _____ Non-swimmer: _____

Fears water? YES ☐ NO ☐ Enjoys water? YES ☐ NO ☐

What kinds of activities are avoided or difficult for the Applicant? _____

What activities are of greatest interest to the Applicant? List skills, hobbies, etc.:

COMMENTS

Present Self-Help Skills, Social Skills and Mobility

Personal Care and Hygiene

Please score the Applicant's ability on the items listed below with the following number rating:

1. **Cannot** perform skills independently or correctly.
2. Requires **much assistance** to perform skill correctly.
3. Requires **some assistance** to perform skill correctly.
4. Performs skill **independently** and correctly.

Note: If the item is Not Applicable, please indicate N/A

Toileting

_____ Control of bowel & bladder needs
_____ Can get on toilet
_____ Can adjust clothing properly
_____ Can use toilet paper properly
_____ Can get off toilet
_____ Can re-adjust clothing properly
_____ Can flush toilet

Hair Care

_____ Can comb and brush hair acceptably
_____ Can shampoo own hair
_____ Can dry own hair
_____ Can set own hair

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Brushing Teeth

_____ Can use proper amount of toothpaste

_____ Can use proper brushing motions

_____ Can rinse mouth

Shaving

_____ Can adequately use electric shaver

_____ Can give proper care to shaver

_____ Can use proper brushing motions

Menstrual Period

_____ Can make adequate use of sanitary aids

Bathing

_____ Can operate faucets on sink

_____ Can operate faucets in tub or shower

_____ Can use adequate amount of soap

_____ Can use towel and wash cloth properly

_____ Is able to get in and out of tub and shower

_____ Can wash hands clean

Housekeeping

_____ Can make own bed

_____ Can clean own room

_____ Can keep bureau and closets in acceptable order

Dressing

_____ Can choose adequate clothing appropriate for physical/social situation

_____ Can put on undergarments

_____ Can put on shirts, blouses

_____ Can put on pants or dress

_____ Can operate fasteners

_____ Can put on loafer-type shoes

_____ Can put on and buckle belt

_____ Can hang clothes in closet

_____ Can put on coat, hat, scarf and gloves

_____ Can clean glasses and put back in case

Eating/Feeding

Does your child currently have a feeding/eating disorder? YES ☐ NO ☐

Has your child ever received services for eating/feeding and/or OT addressing oral motor delays? YES ☐ NO ☐

Does your child have any of the following feeding problems? Please check all that apply.

- ☐ Food Refusal (refusing all or most foods)
- ☐ Food Selectivity by Type (eating only a narrow variety of foods)
- ☐ Food Selectivity by Texture (eating only textures that are not developmentally appropriate)
- ☐ Oral Motor Delays (problems with chewing, lip closure or tongue lateralization)
- ☐ Dysphagia (problems with swallowing)
- ☐ Abnormal Preferences (e.g., refuses food if not a certain temperature, eats only certain brands, must have a certain utensil or a certain dinnerware to eat)
- ☐ Other Feeding Problems (please describe: _____)

*If you identify that your child currently has feeding difficulties and/or a feeding disorder, we will contact you to complete a **Food Assessment Survey**. Please note that Melmark New England has a history of successfully working with students with a variety of eating/feeding challenges.*

Communication

	Consistently	*Sometimes*	*Never*		*Consistently*	*Sometimes*	*Never*
Speaks freely and easily				Uses manual language			
Talks mainly in phrases				Writes or prints			
Uses single words				Understands simple questions			
Communicates with gestures				Follows simple commands			

Social Adjustment

	Consistently	*Sometimes*	*Never*		*Consistently*	*Sometimes*	*Never*
Gets along with siblings				Accepts supervision from parents			
Gets along with other children				Accepts supervision from teachers			
Needs close supervision				Shows interest in the opposite sex			
Disrupts group activities							

If you feel the above does not present a clear picture of the Applicant, please describe him/her more completely:

Mobility

	YES	NO		YES	NO
Walks freely without assistance	☐	☐	Non-ambulatory but uses adaptive equipment	☐	☐
Walks but requires verbal encouragement	☐	☐	Non-ambulatory using adaptive equipment but requires assistance with transfers	☐	☐
Walks with physical assistance	☐	☐	Non-ambulatory, requires total assistance	☐	☐

Please list any prosthetic devices used by the Applicant:

1. _____
2. _____
3. _____

COMMENTS

Educational and Vocational Information

An up-to-date Psychological evaluation and/or Individualized Education/Habilitation Program from the Applicant's previous school and/or residence must accompany this application.

Is Applicant attending school now? YES ☐ NO ☐ If not, please explain briefly: _____

Name of School where Applicant is currently enrolled: _____

Address: _____
Street Address

_____
City *State* *ZIP Code*

Graded? YES ☐ NO ☐ Special? YES ☐ NO ☐

Name of School District responsible for Applicant's education: _____

Address: _____
Street Address

_____
City *State* *ZIP Code*

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Applicant's Age when entered any kind of school for the first time: _____ Describe Applicant's attitude regarding school: _____

Please describe Applicant's attention span and ability to follow directions:

Please list, in order of attendance, all schools and institutions in which the Applicant has been enrolled. (Include preschool, nursery school, kindergarten and tutors.)

Name of School: _____ Address: _____

Dates Attended: From _____ To _____ Grades Covered: _____
Briefly describe Applicant's adjustment to the school situation: _____

Name of School: _____ Address: _____

Dates Attended: From _____ To _____ Grades Covered: _____
Briefly describe Applicant's adjustment to the school situation: _____

Name of School: _____ Address: _____

Dates Attended: From _____ To _____ Grades Covered: _____
Briefly describe Applicant's adjustment to the school situation: _____

Name of School: _____ Address: _____

Dates Attended: From _____ To _____ Grades Covered: _____
Briefly describe Applicant's adjustment to the school situation: _____

Has there been any difficulty with the Applicant's behavior in a school situation? If so, please describe briefly:

To what kind of discipline does the Applicant respond? _____

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Please list below any available test scores and dates:

Test	*Score*	*Date*

Present Dietary Restrictions*

If the Applicant is currently on a special diet, please identify the specifics:

Is this diet prescribed as a diet therapy? YES ☐ NO ☐

COMMENTS

Present Biomedical Procedures*

If the Applicant is currently receiving any bio-medical procedures [e.g., secretion therapy, Kelation therapy, other hormone therapies (ACTH), immunologic therapies (IVIG), anti-yeast therapies, vitamin therapies], please identify the specifics:

Melmark New England Position Statement

In referencing the "**Clinical Practice Guideline: Report of the Recommendations for Autism/Pervasive Developmental Disorders**," it is Melmark *New England*'s position that there is insufficient evidence to recommend the use of hormone therapies, immunologic therapies, anti-yeast therapies, vitamin therapies and diet therapies for the treatment of Autism. Although we respect families for all their efforts in attempting to identify practices and therapies that may assist their child, Melmark *New England* recognizes the importance of using scientific evidence as the basis for informed decisions for the treatment of Autism.

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Miscellaneous

Please identify your **Vision Statement** for your child:

Please identify your **Primary Objectives** for seeking placement consideration at Melmark *New England*:

1.

2.

3.

4.

5.

Please identify your **Concerns** with your child's current setting:

1.

2.

3.

4.

5.

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Is your school LEA aware that you are currently assessing alternative placements for your child? YES ☐ NO ☐

Do you currently have confirmed funding for your child from your school district? YES ☐ NO ☐

What is the current staff to student ratio that your child is currently receiving? _____

Melmark *New England* operates the school and residence at a ratio of 1 staff for every 2 students. Students receiving 1:1 services are provided additional supports for significant educational or behavioral safety issues. ***Students requiring 1:1 services must receive prior approval from funding source (e.g., public school district's LEA, etc.).***

Do you anticipate that your child will require 1:1 service delivery? YES ☐ NO ☐ If yes, please identify why: