HIGH HOPES
APPLICATION FOR ADMISSION

HIGH HOPES HEAD INJURY PROGRAM is a nationally recognized, one of a kind program dedicated to helping brain injured individuals recover their lives. High Hopes is the first program of its kind in the country and we are looking forward to helping you and your family. The goal of HIGH HOPES is to provide comprehensive rehabilitation services for the head injured leading to maximum independence for the individual within the community at a low cost. We provide adult services to those who meet the entrance criteria.

SERVICES: HIGH HOPES HEAD INJURY PROGRAM provides the best day treatment program possible at an affordable cost. These include: Occupational Therapy, Physical Therapy and Speech Therapy. Physical Programs, Re-Socialization, Cognitive Retraining, Independent Living Skills Development, Pre-Vocational Training, and Computer Assisted Instruction. High Hopes goal is to provide the best program at the lowest cost possible.

TAX STATUS: HIGH HOPES operates as a non-profit organization in California, under Internal Revenue Service Code 501-C (3). All donations are therefore, tax deductible as allowed by law.

FINANCE: HIGH HOPES relies on fees for services, and the generosity of the community for its support. Contributions, bequests, gifts, grants and fund raisers provide scholarship assistance for those who can not afford services.

CREDENTIALS: HIGH HOPES is licensed by the State of California, Department of Social Services as an Adult Treatment Facility. We are vendored by the Regional Center of Orange County. We have a highly qualified professional staff with many years service and have provided successful outcomes for hundreds of brain injured individuals.

FACILITIES: HIGH HOPES maintains a 12,000 square foot facility in Tustin. We utilize local resources such as the community pool, and the local 24 Hour Fitness Center. Our facility is located at 2953 Edinger Avenue, Tustin, CA 92780.

FOR FURTHER INFORMATION ON HIGH HOPES PLEASE CALL (949) 733-0044

Application Checklist

1. _______ 3 Page Applicant Information (Signatures on Last Page)
2. _______ Emergency Data Sheet
3. _______ Fee Information and Agreement
4. _______ Physician's Release and Report for Admission (Filled out & Signed by Physician)
5. _______ Records Release Form (Send to Doctors, not to High Hopes in order to get medical records)
6. _______ 2 Page Request for Scholarship Funds (Optional)
7. _______ Personal Rights Adult Community Care Facilities (State Form)
8. _______ Consent For Emergency Medical Treatment (State Form)
9. _______ Physician's Report For Residential Care Facilities For the Elderly (State Form; Filled out by Physician)
APPLICANT INFORMATION

Name of Prospective Student __________________________
The following application is to be completed by the prospective student. If the prospective student is unable to complete the application, please explain why?

________________________________________________________________________

Name of Person Completing the Application ____________________________
Relationship to Prospective Student ________________________________

PROSPECTIVE STUDENT’S INFORMATION

Name_________________________ Date of Birth___________ Age________
Social Security Number__________________________
Home Phone________________ Cell__________________ Email_________________
Address of Residence____________________________________________________
City_________________________ Zip___________________
Residence is: (check one)
_____Group Home  _____Care Facility  _____ Lives with Family
_____ Lives on their Own  _____ Other_____________________
Name of group home or facility____________________________________________

What means of transportation will you use in getting to classes?
( ) Drive self  ( ) Family/friend
( ) Walk  ( ) Public Transportation  ( ) Other________________

Have you ever been arrested for anything other than a misdemeanor? ( ) Yes ( ) No
If yes, what charge________________________________________________________
When_________________________________ Disposition_________________

Are you on probation? ( ) Yes ( ) No Have you ever been on probation? ( ) Yes ( ) No
If yes, date_________________________________________________________________

Guardian’s Name_________________________________ Relation_________________
Address (if different from student)________________________________________________
City_________________________ Zip___________________ Email___________________
Home Phone:_____________________ Work___________________ Cell________________

CURRENT MEDICAL DATA

Present Physician__________________________________________________________
Address_________________________________________________ Phone__________________
Present Medical Problems___________________________________________________

Do you suffer from
( ) Hearing impairment, if so what degree_______________________________________
( ) Visual impairment, if so what degree___________________________________________
( ) Paralysis, if so what degree__________________________________________________
( ) Incontinence
Have you ever tested positive for the HIV (AIDS) virus? _____________________________
Date Tested _______________________ ( ) Positive ( ) Negative
Do you use: ( ) Wheelchair ( ) Quadcane ( ) Cane ( ) Walker
Can you use the restroom facilities unaided? ( ) Yes ( ) No
Have you ever had a seizure? ( ) Yes ( ) No
If yes, give the date of the last seizure______________ How many in the last 12 months________
Allergies: ___________________________________________________________________
Have you ever been treated for alcoholism or drug abuse? ( ) Yes ( ) No
If yes, when were you treated?_________ What treatment? ____________________________

MEDICAL HISTORY
Date of trauma __________________________ Age at time of trauma? ______________________
If in coma, how long? ____________________
Please describe accident, injury, or cause of trauma____________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

MEDICAL CARE RECEIVED AFTER TRAUMA

<table>
<thead>
<tr>
<th>Hospital</th>
<th>City</th>
<th>Physician</th>
<th>Dates</th>
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CARE FOLLOWING HOSPITAL (Acute Care etc.)

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

PSYCHIATRIC CARE (Counseling, Psychotherapy, etc.)
Include pre and post-trauma care

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<th>Site</th>
<th>City</th>
<th>Contact</th>
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EDUCATIONAL HISTORY PRIOR TO TRAUMA

High School Attended________________________________ Date of Graduation____________
Circle last grade completed 9 10 11 12 13 14 AA BA MA Ph.D.
Education after High School________________________________________________________
_____________________________________________________________________________________

EDUCATION/REHABILITATION SINCE TRAUMA

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OTHER SERVICES

Are you presently the client of another agency?  ( ) Yes  ( ) No

If yes, what agency?_____________________________________________________________

Address_________________________________________Phone_____________________

Counselor/Contact____________________________________________________________

WORK HISTORY PRIOR TO TRAUMA

Employer  City  Position  Dates
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Are you currently working? ( ) Yes  ( ) No

If yes, what type of position?__________________________Employer__________________________

How long have you held this position?_____________________

I hereby declare the statements and answers in this application are true and complete to the best of my
knowledge. I authorize investigation of all statements contained in this application, and I hereby
release from all liability and person(s) or organization(s) furnishing such information. I understand
that falsification, misrepresentation, or omission of the facts is reasonable cause for rejection of the
application, and removal of my name from consideration from the HIGH HOPES HEAD INJURY
PROGRAM.

__________________________________________________________
Date

__________________________________________________________
Applicant's Signature

__________________________________________________________
Date

Signature of Parent or Legal Guardian or Caretaker

AUTHORIZATIONS

I grant my approval for ___________________________to participate in High Hopes programs and
activities at 2953 Edinger Ave., Tustin, CA 92780 and at locations away from the facility in activities
supervised and planned by the High Hopes staff. I release High Hopes Head Injury Program from any
liability from my son/daughter/spouse/self participating in said programs. I understand that High
Hopes DOES NOT provide health and medical insurance for the participants. Consent is hereby given
to High Hopes Instructors and Supervisors to give or seek medical aid as required in the case of an
emergency.

____________________________________  __________________________________
Signature of Applicant  Date  Guardian/Caretaker/Parent  Date

I authorize High Hopes to take photographs and films of the above named individual for his/her chart,
professional education publications, study and various publications used inside or outside High Hopes.
I give permission to use his/her/my name in all such publications.

____________________________________ _________________________ ___________
Signature of Applicant  Date  Guardian/Caretaker/Parent  Date
HIGH HOPES HEAD INJURY PROGRAM
EMERGENCY DATA SHEET

Student Name_____________________________ Date of Birth___________________
Phone (____)__________________________
Address_______________________________________________________________________
                                          Street  City  Zip Code
(1) Legal Guardian/Person To Notify in a Emergency ____________________________
Relation_________________ Cell (___)______________ Home (___)______________
Work (___)______________ Email________________________
(2) Legal Guardian/Person To Notify in a Emergency ____________________________
Relation_________________ Cell (___)______________ Home (___)______________
Work (___)______________ Email________________________

Person to Contact for Attendance Purposes___________________________________ Relation_________________
Cell (___)______________ Home (___)______________ Work (___)______________
Email________________________

Medical Information

Date of Trauma________________________

Medications: Type____________________Mg. Dosage__________Times per day__________
       Type____________________Mg. Dosage__________Times per day__________
       Type____________________Mg. Dosage__________Times per day__________
       Type____________________Mg. Dosage__________Times per day__________

Allergies_____________________________________________________________________
_____________________________________________________________________________

Seizures_____/_____Type______________ Date of last seizure__________________________

Yes No

Primary Physician______________________________ Phone(___)______________________

Authorization for MEDICAL TREATMENT: I hereby authorize High Hopes Head Injury Program to
make emergency first aid treatment as High Hopes may feel is indicated. Furthermore, I request High
Hopes to take the above named individual to a hospital if further treatment is required. I understand
that payment for emergency medical treatment will be the responsibility of the individual and/or the
legal guardian. I also understand that the above named person is participating in High Hopes programs
and activities at his/her own risk.

________________________                  ______________________________________________
Date                                          Applicant's Signature

________________________                  ______________________________________________
Date                                          Signature of Parent or Legal Guardian or Caretaker
HIGH HOPES HEAD INJURY PROGRAM
FEE INFORMATION & AGREEMENT

HIGH HOPES HEAD INJURY PROGRAM was the first head injury program in the country. Our program fees are designed to meet the costs of providing services. When compared with other head injury programs, our fees are by far less, since our program is non-profit. Other programs are charging a national average of $1,500.00 per day or $35,000.00 per month. The results of our program have been outstanding. Our goal is to provide the best program possible at an affordable cost.

WHEN APPLYING: $50.00 application fee must accompany your application.

WHEN STARTING: First months tuition is due on the first day of class.

PROGRAM FEES: Full-time student fee is $3,500.00 per month.
Part Time Fee is $2,000.00 per month.

MONTHLY FEES: Tuition statements are mailed out at the beginning of the month. Tuition fees are not determined by attendance. Payment should be received before the 15th of the month. Fees are expected to be paid on time in order to continue receiving services. All fees are nonrefundable.

SCHOLARSHIP FUNDS: With community support through donations and grants, scholarship funds may be available. Scholarships are designed to offset some of the cost of services for those who cannot afford program fees. Applications are reviewed annually providing funds are available. If applying for scholarship assistance, please return the enclosed scholarship form as soon as possible. All scholarship recipients MUST participate in High Hopes' fundraising events.

RECEIVE: High Hopes provides full service day treatment. Services include physical therapy, speech therapy, occupational therapy, cognitive retraining, vocational services, and advanced robotics.

YOUR INSURANCE: Insurance companies may cover all or part of our fees. Families/significant others should follow up with your insurance company to see if our fees are covered. Of course, our office will be responsible for all documentation, including progress reports necessary for your reimbursement.

I have read the above fee information and I do understand my responsibility in meeting my obligation in order to receive services through High Hopes Head Injury Program.

_________________________________  ______________________________________________
Date                        Applicant's Signature

_________________________________  ______________________________________________
Date                        Signature of Parent or Legal Guardian or Caretaker
PHYSICIAN'S RELEASE & REPORT FOR ADDMISSION

Note to Physician: This is part of your patient's application for admission to High Hopes Head Injury Program, Day Treatment Program. This facility provides the personal care and supervision normally provided by a relative or a member of the family. A current health report is required on each person in the facility.

Name:______________________________________Date of Birth:__________ Age: _______
Height:__________ Weight: _____________  Blood Pressure_______________

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<tr>
<th></th>
<th>Normal?</th>
<th>Comments (List any Impairments)</th>
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<tbody>
<tr>
<td>General Health</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Ears</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nose/Mouth/Throat</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

TB Exam Active or Quiescent ____________ Inactive or None ______________________
Any Contagious or Infectious Diseases? _______________________________________

Medications: Type____________________ Mg. Dosage__________ Times per day__________
            Type____________________ Mg. Dosage__________ Times per day__________
            Type____________________ Mg. Dosage__________ Times per day__________

Allergies____________________________________________________________________
Special Diet:_________________________________________________________________
Seizures_____/_____Type______________Date of last seizure_______________________
            Yes No

__________________________ (name of applicant) was given a routine physical examination for the purpose of participating in the HIGH HOPES special education program. I certify that he/she may actively participate in the Adapted Physical Educational/Therapeutic Recreation programs designed to enhance sensory motor and physical abilities as well as passive and active leisure time activities.

Limitations or Restrictions For Activities and Programs:______________________________
______________________________________________________________________________
______________________________________________________________________________

___________________________________  ________________________________ _______
Physician's Name (print)    Physician's Signature

___________________________________  ________________________________ _______
Address                   Phone Number
HIGH HOPES HEAD INJURY PROGRAM
RECORDS RELEASE FORM

Note to Applicant: This form may be used to ask your doctor/therapist to send your medical records to High Hopes. If you decided not to use this form, High Hopes still needs a copy of your medical records.

Instructions: Fill in the name and addresses of the doctor, therapist or hospital at the top of the page. Sign your name at the bottom of the form and mail the form to your doctor/therapist. **DO NOT MAIL THIS FORM TO HIGH HOPES!** When your doctor receives this form he/she will send us the records you have requested.

To:___________________________________________________________________________
   (Contact Person)
   ____________________________________________________________________________
   (Agency Name)
   ____________________________________________________________________________
   (Street Name and Number)
   ____________________________________________________________________________
   (City)  (State)  (Zip Code)

RE:____________________________________  Date of Birth_________________________
   (Patient's Name)

I hereby request and authorize you to release to High Hopes Head Injury Program any medical, psychological, social, vocational, and/or educational testing information you have, or may receive, pertaining to me. I am assured by High Hopes that such information will remain confidential and be used on my behalf towards the effectiveness of my individual program.

_________________________________________  ________________________________
   Date  Signature of Student

_________________________________________  ________________________________
   Date  Signature of Parent/Legal Guardian/Caretaker

Please mail records to:

(Prefer records on a CD but will accept a paper copy)

High Hopes Head Injury Program
Attn: Tracey Desmond 2953
Edinger Ave. Tustin, CA 92780
REQUEST FOR STUDENT SCHOLARSHIP FUNDS

High Hopes Head Injury Program has established a special student scholarship fund to assist students and families who are unable to pay the program fee in full. It is only by contributions from individuals, grants, and companies that we are able to provide this assistance.

Scholarships are reviewed yearly and possible adjustments may occur depending on the need for assistance and the availability of funds. There are also specific responsibilities that are mandatory in order to remain eligible for funding. Failure to comply with the mandatory responsibilities will result in cancellation of scholarship funding. These mandatory responsibilities include:

**Students and their Families are expected to participate in all High Hopes fundraising activities by selling tickets, obtaining sponsorship and donations, or volunteering time.**

Please complete the following:

<table>
<thead>
<tr>
<th>I, _____________________________ request a monthly contribution from the Student Scholarship Fund in order to reduce my individual program fee. I understand funding my request for assistance is dependent on my needs and availability of Scholarship Funds. My scholarship assistance will not exceed 50% of my monthly fee. I am requesting the following amount of Scholarship assistance each month $_______ to offset my monthly fee.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Please Provide general documentation to support the following requested information</em> (Tax returns, SSI, SSDI, copies of check stubs, etc.)</td>
</tr>
<tr>
<td>Financial Information of Prospective Student:</td>
</tr>
<tr>
<td>Monthly Total Income:_______________</td>
</tr>
<tr>
<td>Sources of Income and Amount:</td>
</tr>
<tr>
<td>Employment Income:____________________</td>
</tr>
<tr>
<td>Settlement Income:____________________</td>
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<tr>
<td>SSI Income:__________________________</td>
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<tr>
<td>SSDI Income:________________________</td>
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<tr>
<td>Other Income________________________</td>
</tr>
<tr>
<td>Family Support Information: (The following information is requested if the family is providing financial support for the student)</td>
</tr>
<tr>
<td>Does the Student live with the family? _______Yes_________No</td>
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<tr>
<td>Number of Dependents ________________________________</td>
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<tr>
<td>Current Financial Support includes: (Please Check or List Items)</td>
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<td>Housing ________________________________</td>
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<tr>
<td>Food _________________________________</td>
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<tr>
<td>Transportation ____________________________</td>
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<tr>
<td>Therapy Services __________________________</td>
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<tr>
<td>In Home Support ___________________________</td>
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<tr>
<td>Other Expenses ___________________________</td>
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<tr>
<td>Yearly Gross: ___________________________</td>
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Thank you for completing this form. All information will remain confidential.
PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

EXPLANATION: The California Code of Regulations, Title 22 requires that any person admitted to a facility must be advised of his/her personal rights. Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of persons admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each person admitted to an adult community care facility. The form also provides the complaint procedures for the client and representative/conservator. The facility staff or client representative must communicate these rights in a manner appropriate for client's ability.

This form is to be reviewed, completed and signed by each client and/or each representative/conservator upon admission to the facility. The client and/or representative/conservator also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the client's file which is maintained by the facility.

TO: CLIENT OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: At the time of admission I have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22.

(print the name of the facility) (print the address of the facility)

(print the name of the client)

(signature of the client) (date)

(signature of the representative/conservator)

(title of the representative/conservator) (date)

THE CLIENT AND/OR THE REPRESENTATIVE/CONSERVATOR HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS. THIS AGENCY IS:

NAME

ADDRESS

CITY

ZIP CODE

AREA CODE/TELEPHONE NUMBER

LIC 613 (12/02) (Confidential)
PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

Each client shall have rights, which include, but are not limited to the following:

1. A right to be treated with dignity, to have privacy and to be given humane care.

2. A right to have safe, healthful and comfortable accommodations, including furnishings and equipment to meet your needs.

3. A right to be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature. To be free from restraining devices, neglect or excessive medication.

4. A right to be informed by the licensee of provisions in the law regarding complaints, including the address and telephone number of the licensing agency, and of information regarding confidentiality.

5. A right to attend religious services and activities. Participation in religious services and other religious functions shall be on a completely voluntary basis.

6. A right to leave or depart the facility at any time, and to not be locked into any room or building, day or night. This does not prohibit the development of house rules, such as the locking exterior doors or windows, for the protection of the consumer.

7. A right to visit a facility with a relative or authorized representative prior to admission.

8. A right to have communications between the facility and your relatives or authorized representative answered promptly and completely, including any changes to the needs and services plan or individual program plan.

9. A right to be informed of the facility’s policy concerning family visits. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.

10. A right to have visitors, including advocacy representatives, visit privately during waking hours provided the visits do not infringe upon the rights of other consumers.

11. A right to possess and control your own cash resources.

12. A right to wear your own clothes, to possess and use your own personal items, including your own toilet articles.

13. A right to have access to individual storage space for your private use.

14. A right to have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of the telephone in emergencies.

15. A right to promptly receive your unopened mail.

16. A right to receive assistance in exercising your right to vote.

17. A right to receive or reject medical care or health-related services, except for those whom legal authority has been established.

18. A right to move from a facility in accordance with the terms of the admission agreement.

Reference:
California Code of Regulations, Title 22, Division 6 - General Licensing Regulations, Section 80072; Section 81072, Social Rehabilitation Facilities; Section 85072, Adult Residential Facilities; Section 87872, Residential Care Facilities for the Chronically Ill.
CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Adult and Elderly Residential Facilities

AS THE CLIENT, AUTHORIZED REPRESENTATIVE OR CONSERVATOR, I HEREBY GIVE CONSENT TO

_________________________________________ TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE

FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

__________________________________________________ . THIS CARE MAY BE GIVEN UNDER WHATSOEVER

NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE INDIVIDUAL NAMED

ABOVE.

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:


DATE

CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE

(CIRCLE APPROPRIATE TITLE)

HOME ADDRESS

HOME PHONE

( )

WORK PHONE

( )

LIC 627C (ENG/SP) (4/00) (CONFIDENTIAL)
# PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)

## I. FACILITY INFORMATION
(To be completed by the licensee/designee)

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<th>1. NAME OF FACILITY</th>
<th>2. TELEPHONE</th>
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<th>3. ADDRESS</th>
<th>CITY</th>
<th>ZIP CODE</th>
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<th>4. LICENSEE'S NAME</th>
<th>5. TELEPHONE</th>
<th>6. FACILITY LICENSE NUMBER</th>
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## II. RESIDENT/PATIENT INFORMATION
(To be completed by the resident/resident's responsible person)

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<th>1. NAME</th>
<th>2. BIRTH DATE</th>
<th>3. AGE</th>
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## III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(To be completed by resident/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS

3. DATE

## IV. PATIENT'S DIAGNOSIS
(To be completed by the physician)

**NOTE TO PHYSICIAN:** The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered. (Please attach separate pages if needed.)

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<th>1. DATE OF EXAM</th>
<th>2. SEX</th>
<th>3. HEIGHT</th>
<th>4. WEIGHT</th>
<th>5. BLOOD PRESSURE</th>
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6. **TUBERCULOSIS (TB) TEST**

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<tr>
<th>a. Date TB Test Given</th>
<th>b. Date TB Test Read</th>
<th>c. Type of TB Test</th>
<th>d. Please Check if TB Test is:</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
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</tbody>
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<tr>
<th>e. Results: mm __________</th>
<th>f. Action Taken (if positive):</th>
<th>g. Chest X-ray Results:</th>
<th>h. Please Check One of the Following:</th>
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<td></td>
<td>Active TB Disease Latent TB Infection No Evidence of TB Infection or Disease</td>
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</tbody>
</table>

LIC 602A (8/11) (CONFIDENTIAL)
7. PRIMARY DIAGNOSIS:
   a. Treatment/medication (type and dosage)/equipment:

   b. Can patient manage own treatment/medication/equipment? Yes No

   c. If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):
   a. Treatment/medication (type and dosage)/equipment:

   b. Can patient manage own treatment/medication/equipment? Yes No

   c. If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:
   - Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a “conditional state” between normal aging and dementia.
   - Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual’s ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:
    a. Treatment/medication (type and dosage)/equipment:

    b. Can patient manage own treatment/medication/equipment? Yes No

    c. If not, what type of medical supervision is needed?
11. ALLERGIES:
   a. Treatment/medication (type and dosage)/equipment:

   b. Can patient manage own treatment/medication/equipment?   Yes   No
   c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:
   a. Treatment/medication (type and dosage)/equipment:

   b. Can patient manage own treatment/medication/equipment?   Yes   No
   c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>ASSISTIVE DEVICE (If applicable)</th>
<th>EXPLAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Auditory Impairment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Visual Impairment</td>
<td></td>
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<tr>
<td>c. Wears Dentures</td>
<td></td>
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<tr>
<td>d. Wears Prosthesis</td>
<td></td>
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<tr>
<td>e. Special Diet</td>
<td></td>
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</tr>
<tr>
<td>f. Substance Abuse Problem</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>g. Use of Alcohol</td>
<td></td>
<td></td>
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<tr>
<td>h. Use of Cigarettes i.</td>
<td></td>
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<tr>
<td>Bowel Impairment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Bladder Impairment</td>
<td></td>
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<tr>
<td>k. Motor Impairment/Paralysis</td>
<td></td>
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<td></td>
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<tr>
<td>l. Requires Continuous Bed Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. History of Skin Condition or Breakdown</td>
<td></td>
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</tbody>
</table>
14. MENTAL CONDITION

<table>
<thead>
<tr>
<th></th>
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<th>EXPLAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>NO</td>
<td>E</td>
</tr>
<tr>
<td>a. Confused/Disoriented</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>b. Inappropriate Behavior</td>
<td>S</td>
<td></td>
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<tr>
<td>c. Aggressive Behavior</td>
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<tr>
<td>d. Wandering Behavior</td>
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<tr>
<td>e. Sundowning Behavior</td>
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</tr>
<tr>
<td>f. Able to Follow Instructions</td>
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<tr>
<td>g. Depressed</td>
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</tr>
<tr>
<td>h. Suicidal/Self-Abuse</td>
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<td></td>
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<tr>
<td>i. Able to Communicate Needs</td>
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<td></td>
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<tr>
<td>j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items</td>
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<td></td>
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<tr>
<td>k. Able to Leave Facility Unassisted</td>
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15. CAPACITY FOR SELF-CARE

<table>
<thead>
<tr>
<th></th>
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<th>EXPLAIN</th>
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</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>a. Able to Bathe Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Able to Dress/Groom Self</td>
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<td></td>
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<tr>
<td>c. Able to Feed Self</td>
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<td></td>
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<tr>
<td>d. Able to Care for Own Toileting Needs</td>
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<tr>
<td>e. Able to Manage Own Cash Resources</td>
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</tbody>
</table>

16. MEDICATION MANAGEMENT

<table>
<thead>
<tr>
<th></th>
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<th>EXPLAIN</th>
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</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>a. Able to Administer Own Prescription Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Able to Administer Own Injections</td>
<td></td>
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<tr>
<td>c. Able to Perform Own Glucose Testing</td>
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<tr>
<td>d. Able to Administer Own PRN Medications</td>
<td></td>
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<tr>
<td>e. Able to Administer Own Oxygen</td>
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<td></td>
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<tr>
<td>f. Able to Store Own Medications</td>
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<td></td>
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</tbody>
</table>
17. AMBULATORY STATUS:

a. 1. This person is able to independently transfer to and from bed:  Yes  No

2. For purposes of a fire clearance, this person is considered:
   Ambulatory  Nonambulatory  Bedridden

**Nonambulatory:** A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and/or a person who depend upon mechanical aids such as crutches, walkers, and wheelchairs.

**Note:** A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

**Bedridden:** For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

b. If resident is nonambulatory, this status is based upon:
   Physical Condition  Mental Condition  Both Physical and Mental Condition

c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:
   Illness: ____________________________________________________________

   Recovery from Surgery: _____________________________________________

   Other: ___________________________________________________________

**NOTE:** An illness or recovery is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist?

   1. _________ (number of days)

   2. ______________________ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)

   3. If illness or recovery is permanent, please explain: ________________________________

   ________________________________

   ________________________________

   ________________________________

   ________________________________

   ________________________________
e. Is resident receiving hospice care?

- No
- Yes

If yes, specify the terminal illness: ________________________________

18. PHYSICAL HEALTH STATUS:  
- Good
- Fair
- Poor

19. COMMENTS:

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE  
(  )

22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT

23. PHYSICIAN'S SIGNATURE

24. DATE
High Hopes Head Injury Program

Facesheet

Name ____________________________________________________________

UCI # __________________________________________________________

DOB ____________________________________________________________

Emergency Contact Name: _________________________________________

Emergency Contact Phone # _______________________________________

Relationship: ____________________________________________________

Student Description: _____________________________________________

Height: ________________________________

Weight: ______________________________

Eye Color: ___________________________

Hair Color: __________________________

Medical Disabilities: _____________________________________________

Medication, Dosage & Frequency:

_______________________________________________________________

Medication Side-effects:

_______________________________________________________________

Immunization/TB: ________________________________________________

Allergies: _______________________________________________________

Infect/Comm/Cntgs: _____________________________________________

Special Health/Diet Restrictions: _________________________________

Nutritional Needs: ______________________________________________

Update by: ________________________________
Before sharing a name, information and/or photograph in one of our media channels or on our website, the above-listed organization requires a signed release form from all adults and from the parent or legal guardian of any youth under 18.

ADULT:

I, ____________________________________________________ (print name), being over 18 years of age, hereby grant the above-listed organizations, the right to use the name, photograph, biography, city, state, country and article information, without compensation, on their website and in any publication or written material.

Please print below as wish name to appear.

Date: ___________________

Print Name: ____________________________

Signature: ____________________________

Address:______________________________________________________________

Phone number:__________________________________________________________

Email:______________________________________________________________