New Beginnings Inc.

ADMISSIONS PACKET

“Promoting Growth & Independence”

Windsor Corporate Park

2624 Lord Baltimore Drive Suite L

Windsor Mill, MD 21244

P:410-597-8092 F:410-597-8094

Email: admissions@newbeginningsagency.org

Website: newbeginningsagency.org

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Windsor Mill, MD 21244

ADMISSIONS CHECK LIST

Please submit checklist along with admission application. Failure to submit required documents will result in a delay during the admissions process.

Required Documents	Submit To	Submitted
Completed Admissions Application	Admissions Coordinator	
Copy of Birth Certificate	Admissions Coordinator	
Copy of Social Security	Admissions Coordinator	
Card/Insurance and State ID	Admissions Coordinator	
Award Letter from Social Security	Fiscal Department	
Proof of Active Medical Insurance	Admissions Coordinator	
New Beginnings Rep Payee Authorization Form	Admissions Coordinator Agency RN	
Current Doctor's orders and a copy of the most recent Doctor's visits	Admissions Coordinator Agency RN	
A list of all prescribed medications written on PMOF (including reasons)	Admissions Coordinator Agency RN	
Copy of signed Release & Consent Form	Admissions Coordinator	
Physical Exam-within 1 year	Admissions Coordinator Agency RN	
Copy of recent IP/BP and Psych Eval	Admissions Coordinator	
Completed Mobility Application	Admissions Coordinator	

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Check Program(s) for which application is being submitted. Please type or print clearly when completing the application.					
☐ Residential	☐ Respite	☐ Personal Supports	☐ Supported Employment	☐ Day Rehabilitation	☐ Other

I. APPLICANTS GENERAL INFORMATION

Name:			
	Last	First	Middle
Gender:	☐ Male ☐ Female	Religion:	
Ethnicity:	☐ Hispanic ☐ Non-Hispanic	Race:	
Date of Birth:		Place of Birth:	
Current Address:			
	Street	City	State Zip
Permanent Address:			
	Street	City	State Zip
Telephone Number:		E-mail:	

Social Security #:		Type of Income:		Monthly Amount:	$
Medical Assistance #:		Medicare #:		Other:	
Name of Insurance Provider:		Prescription Coverage:			

I. PARENT/GUARDIAN/CAREGIVER INFORMATION

Name:		Relationship to Applicant:	
Current Address:			
	Street	City	State Zip
Contact #:		Email:	

May we send you information via e-mail? ☐ YES ☐ NO

II. APPLICANTS CURRENT LIVING ARRANGEMENTS

☐ Parent	☐ Guardian	☐ Foster	☐ Other:
		Number of Occupants Living in The Home:	
Parents:			
Foster Home:			
Address:			
Phone Number:			
Legal Guardian:		Date Guardian Was Attained:	
Type of Guardianship:	☐ Property ☐ Limited ☐ Medical ☐ Person		

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Current Address:			
Street	City	State	Zip
Contact #:		Email:	

Is the applicant currently residing in a state funded facility and/or agency? ☐ YES ☐ NO

Name of Facility and/or Agency:	
Address:	
Phone Number:	
Director Name:	

III. FAMILY INFORMATION

Father		**Mother**	
Living/Deceased:		Living/Deceased:	
Name:		Name:	
Birth Date:		Birth Date:	
Home Address:		Home Address:	
Home Phone:		Home Phone:	
Occupation:		Occupation:	
Work Phone:		Work Phone:	
Work Address		Work Address:	
Social Security #:		Social Security #:	
Place of Birth:		Place of Birth:	
Marital Status:		Marital Status:	

IV. SIBLINGS

Name:		Age:		Contact #:	
Name:		Age:		Contact #:	
Name:		Age:		Contact #:	
Name:		Age:		Contact #:	

V. FINANCIAL INFORMATION

A. Do the Applicant Receives Any SSI Benefits? ☐ YES ☐ NO

SSI Claim #:		SSI Amount:	$
Name of Wage Earner		Name of Rep Payee:	

B. Do the Applicant Receives Any Veteran Benefits? ☐ YES ☐ NO

V.A. Claim #:		Benefit Amount:	$
Name of Veteran:			

C. Do the Applicant Receives Railroad Retirement Benefits? ☐ YES ☐ NO			
Railroad Retirement Claim #:		Name of Wage Earner:	
D. Do the Applicant Receives Food Stamps? ☐ YES ☐ NO If yes, which county and/or city:			
Case Number:		Food Stamp Amount	$
E. Do the Applicant Have Life Insurance? ☐ YES ☐ NO			
Life Insurance Coverage:		Burial Plot Location:	
Estimated Value:		Type of Burial Plan:	
F. Is the Applicant Currently Working? ☐ YES ☐ NO		For How Long?	
Name of Employer:		Job Title	
Address:			
Supervisor Name		Contact Number:	
G. Other Sources of Applicants Income:			
Applicants Bank:		Account #:	
H. Any Property in Applicants Name ☐ YES ☐ NO			
I. Do the applicant have a trust fund? ☐ YES ☐NO If yes, give name and address of trustee:			
Trust Fund:			
Address:			
Type:			

VI. MEDICAL

A. Applicant's primary health care provider/physician Name:			
Address:		Phone Number:	
Date of Last Physical Exam:		Examined By:	
Hospital familiar with applicant (if any):			

B. Diagnosis		Age of Onset
Primary:		
Secondary:		
Tertiary:		

C. List any medication(s) taken by applicant

Name	Dosage	Reason

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D. Most Recent Hospitalizations

Date	Reason	Hospital	Physician

E. Seizures

1. Does the applicant have seizures? ☐YES ☐ NO
2. Frequency: ☐Daily ☐Weekly ☐ At least once a month ☐ Every few months
3. Type of Seizures:
4. Are seizures controlled by medication? ☐ YES ☐ NO

F. Applicants Mobility

☐ Walks independently ☐ Uses a cane ☐ Uses crutches ☐Uses walker
Uses wheelchair? ☐ YES ☐NO ☐Manual ☐Electric ☐Self propelled

Do the applicant receive MTA Mobility Services? ☐ YES ☐ NO
If no, applicant must have completed mobility application in order to continue with admissions.

G. Vision

1. Vision Impaired? ☐YES ☐ NO
2. Does the applicant wear glasses or contact lenses? ☐YES ☐ NO
3. Last Eye Examine?
4. Legally Blind? ☐YES ☐ NO

H. Hearing

1. Does the applicant have a hearing problem? ☐ YES ☐NO
2. Does the applicant wear a hearing aid? ☐ YES ☐ NO
3. Date of last hearing exam? Deaf? ☐ YES ☐ NO

I. Dental

1. Date of last dental exam? Dentures? ☐ YES ☐NO
2. Description of dental problems:

J. Equipment Needed

☐ Hoyer Lift ☐ Bed Rails ☐Oxygen ☐Other adaptive/special equipment:

K. Allergies (bees, drugs, dust, mold, food, etc.)

Any other medical problems not listed? ☐ YES ☐ NO

Diet (copped food, tube feeding):

VII. SPEECH & LANGUAGE

1. Speech/Language Impairment? ☐ YES ☐ NO
2. Is Applicant Verbal? ☐ YES ☐ NO
3. Has the applicant had a speech assessment? ☐ YES ☐NO
4. Assessment done by:
5. Means of Communication? ☐ Speech ☐ Sign Language ☐Gestures ☐Communication Board

VIII. MENTAL HEALTH

1. Does the applicant have a history of mental health treatment, alcohol or substance abuse? ☐ YES ☐ NO

List previous treatment and dates:

Date	Treatment Center	In-Patient or Out Patient	Physician/Counselor

2. Is the applicant currently in treatment? ☐ YES ☐ NO
3. Name of the psychiatrist/counselor:

Diagnosis:

IX. PYSCHOLOGICAL INFORMATION

1. Date of last psychological evaluation:
2. Performed By:
3. Address:
4. Diagnosis:

Does the applicant have a history of behavioral problems? ☐YES☐NO

Behavior	Frequency	Severity	Intervention

Has the applicant ever been convicted of a crime? ☐ YES ☐ NO

Provide Details:

Is any other family member diagnosed as having a disability? ☐YES ☐NO

Describe: Click or tap here to enter text.

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X1. EDUCATION

Name of Schools Attended	Complete Address	Date

Adult Programs Attended	Complete Address	Date

Vocational Training or Evaluation	Complete Address	Date

SKILLS CHECKLIST
A. Is applicant independent in personal self-care skills? ☐YES ☐NO
Type of assistance needed when toileting:
B. Can Applicant Self-Medicate? ☐YES ☐NO
C. Can Applicant Cross Streets? ☐ YES ☐NO
D. Can Applicant Use Mass Transit? ☐ YES ☐ NO
E. Is Applicant Capable of Remaining at Home Unsupervised? ☐YES ☐NO
If yes, how long?
F. Can applicant read? ☐YES ☐ NO
G. What does the applicant like to do with his/her free time?
H. What goals does the applicant have?
I. Please provide a brief description of the applicant's daily routine:
Has the applicant received or is receiving any type of services or financial assistance from any other agency? (I.e. Respite services, in-home supports) ☐ YES ☐NO If yes, please list agency/agencies and explain in detail:


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Signatures			
Signature of Applicant:		Date:	
Signature of Parent/ Guardian:		Date:	
Signature of Person Completing this Form:		Date:	

Please mail or fax completed application to
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CONSENT FOR RELEASE OF INFORMATION

Consumer Name: _____ **Date of Birth:** _____

Current Address: _____
Street City State Zip

Last four of SS #: _____

I, hereby authorize the exchange of information between:

_____
(Name of person or organization)

_____
(Address of person or organization)

And NEW BEGINNINGS, INC.
This may include the following: Social History, Psychological Reports, Vocational Evaluations, Medical Information, Counseling Reports, and Discharge summaries.
I understand that the information being requested will be used by New Beginnings Inc to assist in determining the agency's capacity to support me now and/or assist in planning with me in the future.
shall remain effective for a period of one (1) year from the date of my signature, and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (PL 93-575).
I understand that I have the right to revoke this authorization in writing at any time except to the extent that action on this authorization has already occurred (i.e. the information was already distributed).
It is agreed that the recipient of this will refrain from an at will protest disclosure of any information received without authorization by further consent of the client or his/her parents, guardian, or authorized representative, unless provided for, under law or regulation.

Individual and/or Guardian Printed Name: _____ **Date:** _____

Individual and/or Guardian Signature: _____

Witness: _____

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New Beginnings Rep Payee Authorization Form

Individual Name:		Date of Birth:	
Address:			
Social Security Number:			
Do the individual have a legal guardian? ☐ YES ☐ NO			
Legal Guardian Name:		Date of Birth:	
Address:			
Phone Number:			

Consent

I hereby, give New Beginnings Inc. consent to become my rep payee. I understand by New Beginnings Inc. becoming my rep payee, New Beginnings responsibilities as my rep payee includes:

- Awareness of my current day-to-day needs (i.e., food, clothing, shelter, medical expenses and personal items)
- Use of my payments to meet my needs;
- Conserve any money left over, after meeting my current needs, in a checking or savings account (preferably interest-bearing), U.S. savings bonds, or other appropriate investment(s) that is titled in a way that clearly establishes my ownership;
- Plan to spend wisely, or conserve, in my best interests, of any large payment I receive;
- Report any event that may affect my entitlement to benefits or payment amount such as a return to work.
- Return any overpayment promptly (i.e., any payment Social Security determine is not due to me);
- Keep records of all payments Social Security make to me, all bank statements, and receipts or cancelled checks for rent, utilities, and any major purchases made for the beneficiary
- Notify Social Security of any changes or circumstances that would affect New Beginnings Inc. performance as a payee;
- Return to us any of the beneficiary's funds New Beginnings Inc. have conserved after stop serving as payee;
- Notify Social Security Administration in the event I die while New Beginnings Inc. is the rep payee and turn over any conserved funds owned by me to the legal representative of my estate for disposition under State law.
- Notify Social Security Administration if my condition improves to a point where I no longer need a payee;
- Submit the appropriate forms for our periodic reviews or redeterminations of SSI eligibility factors.
- Submit a written or online report, at Social Security Administration request, of how New Beginning Inc. spent or conserved my benefits
- Promptly report misuse or employee theft of beneficiary funds to Social Security Administration.

Individual Printed Name:		Date: _____
Individual Signature:		
Legal Guardian Printed Name (if applicable):		Date: _____
Legal Guardian Signature (if applicable):		
Witness:		

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