ICM
B.R.A.V.O. Application for Services

1525 Merrill Drive, Little Rock, AR 72211 ● (501) 228-0063 ● Fax 228-0078
www.icm-inc.org

Please attach the following items to the application:

☐ Recent Photo

☐ Birth Certificate (if available)

☐ Copy of Medicaid/Medicare Cards

☐ Copy of Social Security Card

☐ Driver's License

☐ Immunization Record

☐ Legal Guardianship Papers if applicable

☐ High School Diploma or Certificate of Completion (If under 21 years old)

☐ Most Current Psychological Evaluation

☐ Prescription for Services (within last 12 months)

☐ Physical examination/assessment signed by medical professional (on file within 30 days of admission)

Assistance with completing the application will be provided to applicants by a Case Manager or other ICM, Inc. employee as needed.

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APPLICATION FOR ADMISSION **(Office use only)**

Date Application Received:____________________ Date Interviewed:________________

Date of Admission:___________________________ Date Discharged:________________

Referral Source:____

●●●

B.R.A.V.O. Application

Name of Applicant (full):_____ Nickname:_____

Home Address:_____

Home Phone:_____Business Phone:_____Cell Phone:_____

Date of Birth:_____Birthplace:_____

Social Security Number:_____Medicaid Number:_____

Medicare Number:_____Part D Medicare:_____

Medipak Number:_____

Name of Parent:_____Phone:_____

Guardian:_____Address:_____

Legal Status (i.e., competency)_____

Please list details of any of the above services that were received or are now being received by the applicant. Include dates, place, type of service.

_____

_____

_____

_____

_____

_____

PERSONAL AND FAMILY INFORMATION

Briefly comment on the following items:

Social skills (Please check the number that best describes applicant's ability):_____

1. No interaction with anyone ☐	**2.** Interaction limited to family members/staff ☐	**3.** Limited interaction with non-family/staff ☐	**4.** Engages with others when prompted ☐	**5.** Openly engages others in conversation ☐

Abilities/Strengths:_____

Behavior concerns:_____

Relationship with family members:_____

Cultural issues needing consideration:_____

Please list members of the family below:

Name	**Relationship**	**Address**

EMPLOYMENT FACTORS

List any special skills/training that the applicant has for employment purposes:

Employer_____ Supervisor_____

Address_____ Phone_____

_____

Length of employment_____ Salary/wage_____

Former employer_____ Type of work_____

Employer_____ Supervisor_____

Address_____ Phone_____

_____

Length of employment_____ Salary/wage_____

Former employer_____ Type of work_____

FINANCIAL RESOURCES
(Answer Yes/No)

_____ SSI _____Pension/Annuity _____ Savings

_____ SSDI _____Trust _____ Checking

_____ Rep. Payee _____Third Party Insurance
(name of insurance company)

LIABILITY FACTORS

Primary diagnosis (proof must be attached)_____

Secondary diagnosis_____Physical disabilities_____

MEDICAL INFORMATION

List any special medical care, medication, special diets, or physical limitations that pertain to the applicant's care.

_____

_____

_____

_____

Is the applicant currently being treated for a medical condition?_____
If so, explain in detail condition being treated (use back of form if additional space is needed)

_____

_____

List all medications prescribed by a physician applicant is currently taking or any over the counter medication applicant takes on a regular basis.

_____

_____

_____

Does applicant have allergies?_____If so, please list _____

_____

_____

_____

Give dates of last visit to the following with name, address, etc.:

Medical doctor_____

Dentist_____

Optometrist_____

Orthopedic specialist_____

Speech therapist_____

Physical therapist_____

Occupational therapist_____

Counseling service_____

Please list other doctors, hospitals, clinics, agencies, etc. **(with addresses)** that have additional information on the applicant (use back of form if additional space is needed).

_____

_____

_____

Please explain any treatment and/or therapy now being received by the applicant.

_____

_____

_____

Applicant's general health: Good ☐ Fair ☐ Poor ☐

Comment on areas needing "special supervision" or where applicant may be at risk. Address potential or known risk that the applicant may present in new environment.

_____

_____

_____

MEDICAL HISTORY

Name_____Sex_____DOB_____

Address_____Phone_____

Parent/Guardian_____

Address_____Home Phone_____

Employer_____Bus. Phone_____

Family Physician_____Phone _____

Address_____

Insurance Company_____Policy Number_____

Medicare No._____ Medipak No._____

Medicaid No._____ Social Security No._____

IMMUNIZATION RECORD

	Date Original Vaccination	Date Booster Given	Date Reaction Indication	Date Diagnosed
Diphtheria (DTP/DtaP/DT)				
Pertussis				
Typhoid				
Whooping Cough				
Polio (IVP or OPV)				
Tetanus				
Small Pox (Varcella)				
Mumps				
Rubella/Red/3-day/German				
Rubeolla/Hard/10-day Measles				
Hepatitis B				
Chicken Pox				
Tuberculin				
Flu				

INDICATE AGE AT WHICH ANY OF THE FOLLOWING OCCURRED:

_____Asthma
_____Chronic Cough
_____Diabetes
_____Fainting
_____Frequent Depression
_____Hay Fever
_____Headaches/Migraines
_____High Blood Pressure
_____Insomnia
_____Kidney Disease
_____Frequent Constipation
_____Recurrent Head Colds
_____Recent Weight Gain/Loss
_____High Fever
_____Seizure
_____Strep Throat
_____Tuberculosis
_____Herpes
_____Other

_____Convulsive Disorder
_____Cysts, Tumors
_____Dizziness
_____Eye Problems
_____Gallbladder problems
_____Heart Palpitations
_____Hepatitis B
_____HIV/Aids
_____Jaundice
_____Lung Disease
_____Malaria
_____Recurrent Diarrhea
_____Rheumatic Fever
_____Scarlet Fever
_____Sinusitis
_____Stomach/Intestinal Disease
_____Venereal Disease
_____Weakness/Paralysis

SURGERIES

_____Appendectomy
_____Hernia Repair
_____Tubal Legation
_____Corrective Surgery

_____Tonsillectomy
_____Hysterectomy
_____Vasectomy
_____Other

LIST ANY CONGENITAL DEFECTS

_____

_____

_____

_____

_____

Do you have severe headaches?_____How often do headaches occur?_____

_____

Name of medicine(s) you take for headache_____

Have you ever had a seizure?_____Age of first seizure_____

Do you know when you are going to have a seizure? (List warning signs)_____

_____

_____

Do any of the following cause you to have a seizure?_____

Getting too hot_____ Physical exercise_____

Excitement_____ Crowds_____

Have you had an EEG?_____If yes, when?_____Where_____

Name of Neurologist who has treated you_____

_____

Neurologist address

Date of last visit to Neurologist_____

(TO BE ANSWERED BY WOMEN ONLY)

Do you have regular menstrual periods? Yes_____ No_____
(If answered no, please explain)

_____

_____

Describe any problems you have with your periods (such as pain, vomiting, etc.)_____

_____

Are you now, or have you in the past taken birth control pills?_____

Date you began taking birth control pills_____

Date of last menstrual period_____Date of last Pap Smear _____
Name of doctor and clinic where last Pap Smear was done_____
_____

Date of last Mammogram_____

Name of doctor and clinic where Mammogram was done_____
_____

MEDICATION RECORD

Are you allergic to any medicine?_____

Describe allergic reaction_____
_____
_____

List Medication you are currently taking

Medication	Dosage	Doctor	Starting Date	Why medicine was prescribed

List Medications you have taken in the past, but are not currently taking._____
_____
_____

Do you have any food or other allergies?
_____

List any dietary restrictions you may have:
_____

FAMILY HISTORY

	(If Living) AGE	HEALTH	(If Deceased) AGE AT DEATH	CAUSE
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Please indicate any blood relative who has or had the following: **(Check and give relationship)**

☐ Stroke_____ ☐ Epilepsy_____ ☐ Arthritis _____
☐ Cancer_____ ☐ Hay Fever_____ ☐ Leukemia_____
☐ Goiter_____ ☐ Diabetes_____ ☐ Suicide _____
☐ Asthma_____ ☐ Migraine_____ ☐ Colitis _____
☐ Tuberculosis_____ ☐ Heart Attack _____
☐ Stomach Ulcers_____ ☐ Kidney Disease _____
☐ Rheumatic Heart_____ ☐ Congenital Heart _____
☐ Nervous Breakdown_____ ☐ Bleeding Tendency _____
☐ High Blood Pressure _____

PERSONAL HABITS

Mark Yes/ No	
Yes ☐ No ☐	Do you regularly smoke? Cigarettes____Pipe____Cigars____How long_____
Yes ☐ No ☐	Do you usually drink over 6 cups of coffee per day?
Yes ☐ No ☐	Do you regularly drink alcohol?
Yes ☐ No ☐	Do you have difficulty falling asleep?
Yes ☐ No ☐	Do you awaken early in the morning without apparent cause?

Write in names of diseases you have had which required hospitalization:

_____

_____

_____

_____

Describe any serious injuries or accidents_____

_____

_____

List any injury that limits your ability to lift, walk, or participate in physical activities.

_____

_____

_____

Do you wear glasses?_____ How long?_____

Do you wear a hearing aid?_____ How long?_____

Date of last eye exam_____

Name/address of Ophthalmologist:_____

_____

Social History: *(Must be Updated Annually)*

Signature of Parent/Guardian/Applicant **Date**

Signature of ICM Employee Assisting with Application **Date**

ICM, Inc.
INFORMED CONSENT FOR DDTCS SERVICES

NAME:_____DATE OF BIRTH:_____

I understand that as a participant in ICM, Inc.'s programs, I am eligible to receive a range of services. The type and extent of services that I may receive will be determined following an initial assessment and through discussion with myself and my Interdisciplinary Team. The goal of the assessment process is to determine the best possible services and treatment for me.

I understand that all information shared with the staff at ICM, Inc. is confidential and no information will be released without my consent. During the course of treatment at ICM, Inc., it may be necessary for my case manager to communicate with other staff at ICM, Inc. regarding my services. Verbal consent for limited release of information may be requested in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to myself or to another person, the staff is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a person is being sexually, physically, or verbally abused or is at risk of such abuse, the staff is legally required to take steps to protect the person and to inform the proper authorities.
- When any incident occurs that requires mandatory reporting to Developmental Disability Services.
- When a valid court order is issued for medical records, the case manager and the agency are bound by law to comply with such requests.

I understand that ICM, Inc. services are provided by a range of professional staff.

I understand that while services at ICM, Inc. may provide significant benefits, it may also pose some risks.

If I have any questions regarding this consent form or about the services offered at ICM, Inc., I may discuss them with my case manager. I have read and understand the above. I consent to participate in the assessment and services offered to me by ICM, Inc. I understand that I may stop services at any time.

_____ _____
Customer/Guardian Signature Date

_____ _____
ICM Employee Signature Date