APPLICATION FOR ADMISSION

Return information to:
Admissions Coordinator
PO Box 2104
Rapid City, SD 57709
(605) 343-4550

GENERAL INFORMATION

Legal Name: (First)	(Middle)	(Last)
Current Address:		Phone #:
City:	State:	Zip:
Social Security Number:		Date of Birth:
Place of Birth City:	State:	County:
Sex:	Height:	Weight:
Hair Color:	Eye Color:	Identifying Marks:

OPTIONAL INFORMATION

Religion:	Language of Individual Spoken/Understood:

Race: Caucasian _____ African American _____ Hispanic _____ Oriental___
Native American _____ Degree of Blood _____ Tribe _______________

REFERRAL SOURCE

Services requested:_______________________________________

Names, addresses, and phone numbers of other agencies involved:
____

Primary diagnosis: _______________________________________

Secondary diagnosis: _______________________________________

LEGAL INFORMATION

Does applicant have a court appointed legal guardian? _____ Yes _____ No

If yes, Legal Guardian: *(Please attach copies of guardianship papers)*

Does Applicant have any prior legal convictions? _____ Yes _____ No
State circumstances and legal decision:

MEDICAL

Any health problems? Describe:

Current medications:

Does applicant have a seizure disorder?

Type Frequency:

Have there been any recent hospitalizations? If so when and why.

List known allergies:

Does applicant currently operate a motor vehicle? _____ Yes _____ No

TREATMENT PROVIDERS

(List physicians, clinics, mental health centers, public and/or private, hospitals and other rehabilitation facilities where applicant has received treatment, evaluations or training.

Current Physician		Date of last exam:
Address:		Phone #:
City:	State:	ZIP:
Neurologist		Date of last exam:
Address:		Phone #:
City:	State:	ZIP:

Dentist		Date of last exam:
Address:		Phone #:
City:	State:	ZIP:
Optometrist		Date of last exam:
Address:		Phone #:
City:	State:	ZIP:
Hospital		Date of last exam:
Address:		Phone #:
City:	State:	ZIP:
Psychiatrist		Date of exam:
Address:		Phone #:
City:	State:	ZIP:
Psychologist		Date of exam:
Address:		Phone #:
City:	State:	ZIP:
Counselor		Date of exam:
Address:		Phone #:
City:	State:	ZIP:
Other		Date of exam:
Address:		Phone #:
City:	State:	ZIP:
Other		Date of exam:
Address:		Phone #:

FAMILY

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Name of Spouse: | Phone #:

Address:

City: | State: | ZIP:

Name of Father: | Name of Mother:
Father living _______ Yes _______ No | Mother living _______ Yes _______ No

Father's Address:

Phone #:

Mother's Address:

Phone #:

BROTHERS, SISTERS and CHILDREN of APPLICANT

NAME	AGE	RELATIONSHIP

RESIDENTIAL

Does applicant currently have housing available in Rapid City? _____ Yes _____ No

Does applicant live alone? _____ Yes _____ No

If no, with whom does applicant live? ______________________________

Is applicant requesting housing assistance? _____ Yes _____ No

If yes, What type of housing does applicant need? ______________________________

If no, Who would make arrangements? ______________________________

EDUCATION

What Schools Attended?	During What Years?	Reason for Leaving?

Was applicant in regular or special education classes? ______Regular _______Special Education _____Both	Last School grade completed?

Can applicant read? _____Yes _____No

Can applicant write? _____Yes _____No

EMPLOYMENT HISTORY

Has applicant ever been employed? Yes___ No___

*If yes, please complete employment history

Name of Employer		Type of Work
Address:		Hourly Wage:
City:	State:	ZIP:
Job Responsibilities:		
Reason for leaving:		

Name of Employer		Type of Work
Address:		Hourly Wage:
City:	State:	ZIP:
Job Responsibilities:		
Reason for leaving:		

Other information you consider important/helpful?

IN CASE OF EMERGENCY		
Name:		Home Phone:
Address:		Work Phone:
City:	State:	ZIP:
Name:		Home Phone:
Address:		Work Phone:
City:	State:	ZIP:

ALTERNATE EMERGENCY CONTACT		
Name:		Home Phone:
Address:		Work Phone:
City:	State:	ZIP:
Name:		Home Phone:
Address:		Work Phone:
City:	State:	ZIP:

Signature of individual completing form:		Home Phone:
Address:		Work Phone:
City:	State:	ZIP:
Applicants Signature: ______________________________		Date:______________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

BLACK HILLS WORKSHOP AND TRAINING CENTER, INC.

In case emergency treatment is required, I ________________________________ authorize the staff at Black Hills Workshop and Training Center, Inc. To approve any emergency procedures that maybe necessary to insure for the health and well being of:

Signature:____

Or

Guardian Signature (as applicable):______________________________

Date:_________________

(This form is effective for one year or until revoked by the individual.)

BLACK HILLS WORKSHOP AND TRAINING CENTER, INC.

RELEASE of RESPONSIBILITY FORM

I, ______________________________ give consent to the Black Hills Workshop
Name
and Training Center, Inc., or persons or agencies operating in it's behalf, the right and permission to transport myself (my son/daughter) on any planned and supervised extra-curricular activities such as bowling, swimming, games, parties, field trips, etc. sponsored by Black Hills Workshop and Training Center, Inc., I understand that transportation will be provided in insured vehicles.

I also exonerate Black Hills Workshop and Training Center, Inc., from any damages that I (my son/daughter) might cause to any person(s) or property while in their prudent care and custody.

I further understand that I (my son/daughter) may be excluded at anytime if it is judged that my (son/daughter) behavior is detrimental to the purpose and functioning of these activities.

I have read and/or I understand, through discussion, the full meaning of this release.

Signature:______________________________

Or

Guardian Signature (as applicable):______________________________

Date:______________

(This form is effective for one year or until revoked by the individual.)

BLACK HILLS WORKSHOP AND TRAINING CENTER, INC.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, for a period of one year, the release of information to the Black Hills Workshop and Training Center, Inc., where such information appears appropriate from any physician, hospital, school, clinic, agency, or institution having medical, psychological, school or social records concerning:

____
Name

I understand that this information will be used by the staff of Black Hills Workshop and Training Center, Inc., to determine what services are necessary. A photo copy of this authorization shall be as valid as the original.

I have read and/or I understand through discussion the full meaning of this release.

Signature:____

or

Guardian Signature (as applicable):____________________________________

Date:____________________