

HARTVILLE MEADOWS  
844 Sunnyside SW,  
Hartville, Ohio 44632  
330-877-3694

LAFAYETTE MEADOWS  
22052 Orchard Street  
West Lafayette, Ohio 43845  
740-545-6366

APPLICATION FOR ADMISSION

Please check facility: Hartville Meadows \_\_\_\_\_ Lafayette Meadows \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Social Security # \_\_\_\_\_ Medicaid # \_\_\_\_\_ SS \_\_\_\_\_ Yes \_\_\_\_\_ No

Present Living Arrangement: \_\_\_\_\_ Why Placement is requested: \_\_\_\_\_

Presently Attends: Workshop \_\_\_\_\_ (Name of Workshop) \_\_\_\_\_ Other \_\_\_\_\_ Specify \_\_\_\_\_

Case Manager/SSA, if known: Names & Telephone \_\_\_\_\_

Diagnoses \_\_\_\_\_ Seizures? \_\_\_\_\_ Yes \_\_\_\_\_ No

Functioning Level: \_\_\_\_\_ Profound \_\_\_\_\_ Severe \_\_\_\_\_ Moderate \_\_\_\_\_ Mild

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Verbal Skills: \_\_\_\_\_ None or Minimal \_\_\_\_\_ Adequate \_\_\_\_\_ Normal

Communicates: \_\_\_\_\_ Gestures \_\_\_\_\_ Words \_\_\_\_\_ Sentences \_\_\_\_\_ Sign Language

Hearing: \_\_\_\_\_ Deaf \_\_\_\_\_ Impaired \_\_\_\_\_ Normal Vision: \_\_\_\_\_ Blind \_\_\_\_\_ Impaired \_\_\_\_\_ Normal

Behavior: \_\_\_\_\_ Cooperative \_\_\_\_\_ Withdrawn \_\_\_\_\_ Harms Self \_\_\_\_\_ Harms Others \_\_\_\_\_ Destructive

\_\_\_\_\_ Combative \_\_\_\_\_ Noisy \_\_\_\_\_ Wanders

Describe any behavior problems: \_\_\_\_\_

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Toileting: \_\_\_\_\_ Continent \_\_\_\_\_ Incontinent Comment \_\_\_\_\_

For items below, use: I = Independent A = Assistance needed S = With Supervision U = Unable to do

\_\_\_\_\_ walks alone \_\_\_\_\_ uses wheelchair \_\_\_\_\_ walks with crutches \_\_\_\_\_ sits alone

\_\_\_\_\_ dresses self \_\_\_\_\_ bathes self \_\_\_\_\_ combs hair \_\_\_\_\_ shaves

\_\_\_\_\_ feeds self \_\_\_\_\_ uses glass/cup \_\_\_\_\_ brushes teeth \_\_\_\_\_ turns in bed

\_\_\_\_\_ transfers bed/chair \_\_\_\_\_ transfers chair/toilet Can put weight on feet? yes \_\_\_\_\_ no

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Present Therapies: \_\_\_\_\_ Physical \_\_\_\_\_ Occupational \_\_\_\_\_ Speech

Diet: \_\_\_\_\_ Regular \_\_\_\_\_ Blended \_\_\_\_\_ Restrictions, explain \_\_\_\_\_

Regular Medications: (Medication, Dose and Frequency, Purpose)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Other helpful information: \_\_\_\_\_

Physicians Name and Telephone Number: \_\_\_\_\_

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Parent or Guardian: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_

Application filled out by \_\_\_\_\_ above person \_\_\_\_\_ other relationship \_\_\_\_\_ (give name, address,

telephone number) \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Tour Date \_\_\_\_\_ Conducted by \_\_\_\_\_