



Cardinal Cushing Centers

All ages. All abilities. All together.

Cardinal Cushing Centers

405 Washington Street ~ Hanover MA 02339

Phone: 781.826.6371 Fax: 781-826-1559

www.cardinalcushingcenters.org

Thank you for considering Cardinal Cushing Centers. The following information will help us to become acquainted with the applicant. *PLEASE PRINT ALL ITEMS.*

Date of Application _____ Anticipated Date of Admission _____

Please indicate placement interests

- Cardinal Cushing School and/or St. Coletta's Day School
 - Boarding
 - Summer (6-weeks)
 - Afterschool, Weekend, and/or Vacation Recreation Programs

- Cardinal Cushing Adult Services
 - Life Opportunities Unlimited (Day Habilitation)
 - South Shore Industries (Employment)
 - Residential Supports
 - Adult Family Care

BIOGRAPHICAL INFORMATION

Applicant's Name _____ Date of birth _____ Age _____

Place of birth _____ Gender: M F Race _____

Religious Preference _____ Languages Spoken _____

Previously instructed in language other than English? If so, what language: _____

Parent Name _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip Code _____ Business Phone _____

Place of employment _____ Email Address _____

Job Title or Position _____ Work Email _____

Parent Name _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip Code _____ Business Phone _____

Place of employment _____ Email Address _____

Job Title or Position _____ Work Email _____

Parent(s): Married _____ Divorced _____ Separated _____ Single _____ Remarried _____

Guardian Name _____
Address _____
City, State, Zip Code _____
Place of employment _____
Job Title or Position _____

Home Phone _____
Cell Phone _____
Business Phone _____
Email Address _____
Work Email _____

Please list names and ages of siblings: Name _____ Age ____ Name _____ Age ____
Name _____ Age ____ Name _____ Age ____

FINANCIAL INFORMATION

Person(s)/Agency/School System financially responsible for funding placement _____

Billing Address: Source/Name _____
Address _____
City/State/Zip _____
Telephone _____
Email Address _____

Cost Sharing (1) _____ Cost Sharing (2) _____

REFERRAL INFORMATION

How did you hear about Cardinal Cushing Centers?

Name: _____ Profession: _____
(e.g.: consultant, physician, advocate, agency, educator, attorney)

Address: _____

Email: _____ Phone: _____

Other: _____

(e.g.: website, conference, parent group, print ad)

PAST PLACEMENT HISTORY

Please list the four most recent schools and/or facilities the applicant has attended, beginning with the most recent.

Name of school/program _____ Dates attended _____

Location _____ Reason left _____

Name of school/program _____ Dates attended _____

Location _____ Reason left _____

Name of school/program _____ Dates attended _____

Location _____ Reason left _____

Name of school/program _____ Dates attended _____
Location _____ Reason left _____

Diagnosis (please specify)

MEDICAL INFORMATION

Medical Insurance Information (please attach copy of card) _____

Medical Billing is to be forwarded to _____

Name of Policy Holder _____ DOB _____ SSN _____

Does the applicant have any restrictions due to a health-related disorder? If yes, please explain.

Has the applicant ever had major surgery or illnesses? If yes, please explain.

Does the applicant have any particular dental problems? Dental appliances? If yes, please explain.

Does the applicant have food allergies: _____ If yes, please explain:

Swallowing impairment _____ Modified diet physician ordered: _____

Explain: _____

MEDICAL INFORMATION CONTINUED

Does the applicant have: Seizure disorder Yes No Type/Frequency _____
 Hearing impairment Yes No Aid required _____
 Speech impairment Yes No Therapy/Frequency _____
 Visual impairment Yes No Glasses _____

Other Types of Services/Therapies currently: _____ Frequency _____

Sensory items recommended and in use: _____

Adaptive feeding utensils: if so, what _____

Braces, orthotics: if so prescribed and in use: _____

DIAGNOSTIC INFORMATION

Please list previous assessments (attach reports and immunization record):

Physical/Health Exam

Date _____ by whom _____ address/phone _____

Dental Exam

Date _____ by whom _____ address/phone _____

Psychiatric Evaluation

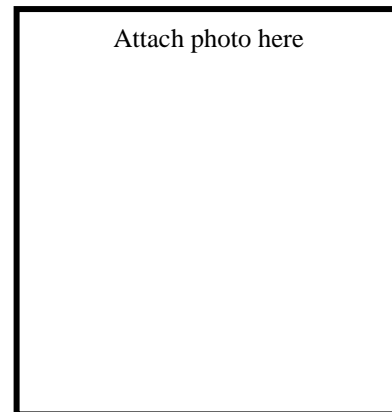
Date _____ by whom _____ address/phone _____

Please attach a current photo to the application.

Height _____ Weight _____

Eye Color _____ Hair Color _____

Identifying marks _____



CURRENT MEDICATIONS

Please list medications currently prescribed*:

Medication and Dosage	Reason for prescription
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any medication allergies _____

PERSONAL COMMENTS

Please describe the applicant’s strengths and challenges:

At home _____

At school or at work _____

Speech and Communication _____

Coping and Self-Management _____

Behavioral concerns _____

List any special interest or hobbies the applicant has _____

PARENT AND STUDENT’S VISION

Please share your vision and goals for the future:

Cardinal Cushing Centers does not discriminate on the basis of race, color, religion, sex, national origin or sexual orientation in our admissions, services, or employment practices.