Cardinal Cushing Centers
All ages. All abilities. All together.

Cardinal Cushing Centers

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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_____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip Code _____ Business Phone _____

Place of employment _____ Email Address _____

Job Title or Position _____ 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 _____

Attach photo here

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.