MacDonald Training Center, Inc.
Empowering People With Disabilities

MTC Use Only
Date Rec'd: ________________
Rec'd by: __________________
Tour Date__________________
Admission Date: ____________

APPLICATION FOR ENROLLMENT

INSTRUCTIONS: Please answer every question. There should be no blanks when the form is returned to MTC. If it does not apply, please mark N/A. In addition, the form must be legible.

Form may be completed online at www.macdonaldcenter.org and may be returned in person, by mail or by email to: MTCAdmissionsTeam@MacDonaldCenter.org.

Date ________________________________ Referred by_________________________________

SECTION I - GENERAL INFORMATION:
(All sections must be completed)

Name ____
Last *First* *Middle Initial* *Nickname*

Social Security #__________________________ Date of Birth: ____________________________

Home address ____
No. and Street City State Zip Code

Is this: *Family Home* Supported/Independent Living Group Home

Agency Name & Contact information: ____

Mailing address *(if different from above)*: ____

Phone #___________________________ Cell #: _______________________

Email ____

Have you been convicted of a felony or any crime? YES No

(*Such a conviction may be relevant if service related, but does not bar you from services).*
If Yes, explain and please include dates and details of all charges.

____
____
____

Services Requested:

LSD3 - Day Training Services
SE - Supported Employment
CL - Supported Living / Personal Supports
Certificate Program (MOS/IC3/CLA/ES)

Emergency Contact *(must be able to respond in person within an hour of contact)*

Name________________________________ Home Phone #_____________________________

Cell Phone #___________________________ Work # ____________________________________

Relationship to applicant: ________________________________

SECTION˙=-7=F7@9˙C:˙GIDDCFHG:

Name of Father: ____________________________ Living Deceased

Address ____

Home Phone # ________________________ Email ______________________________________

Work Phone # ________________________ Cell Phone # ________________________________

Name of Mother ____________________________ Living Deceased

Address: ____

Home Phone #_______________________ Email ____

Work Phone # ________________________ Cell Phone # __________________________________

Legally Competent: Yes No

Legal Guardian Information *(if answered NO)*:

____

Name No. and Street City State Zip Code

Home Phone # ______________________ Cell Phone # __________________________________

Email Address: ____

Type of Guardianship______________________ *(if applicable - please provide guardianship documentation)*

Waiver Support Coordinator (Name)____

Agency ____

Address ____

Phone # _________________________ Email ____

Supported Living Coach (Name) ____

Agency ____

Address ____

Phone # _________________________ Email ____

FAMILY/FRIENDS SUPPORTS

List name, relationship and phone number of siblings, family members, friends or relatives most involved with the applicant that provide support regularly:

____

____

____

SECTION III - EDUCATION:

List schools and other training services in order of attendance and give the number of years attended:

Service	Location	Type of Service	# of years

SECTION IV NEEDED SUPPORTS

Describe behaviors of concern (i.e. self-injurious, physical/verbal aggression, property damage, running away, etc.) Please do not leave this section blank. (*Please indicate the frequency and intensity, contributing factors, triggers, and the date of the most recent incident).*

Yes No Self Injurious Behavior (SIB) ______________________________
Yes No Physical Aggression ______________________________
Yes No Property Destruction ______________________________
Yes No Eloping/Running Away ______________________________

Do you have a behavior plan? Yes No If yes, please submit a copy

Behavior Analyst (BCBA) Name ______________________________

Agency ______________________________

Address ______________________________

Phone # ______________ Email Address______________________________

Indicate the level of supports needed with the following:

Toileting: Independent Needs Prompting Physical Assistance

Wears briefs? Yes No

Mealtimes: Independent Needs Prompting Physical Assistance

Any special considerations at mealtimes?
Special diet / consistency *(If so, please list/describe)*

____

____

Any special adaptive equipment (If so, please list)

____

____

SECTION V - EMPLOYMENT

Are you currently employed? Yes No *If yes, date of hire* ____________

Name of Current EMPLOYER	Address	Phone Number

Scheduled Work Days: ☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat ☐Sun

Are you currently receiving Supported Employment Services? Yes No

If yes:

Name ____________

Agency ____________

Address ____________

Phone # ____________ Email ____________

Are you interested in obtaining employment in the community? Yes No

If yes, what type of work interests you? ____________

What are your goals, hopes, and dreams? What do you want to learn?

SECTION VI OTHER PERTINENT INFORMATION: Please provide information relevant to the health, safety and well being of the applicant:

Is there a history or concern of abuse, neglect and/or exploitation?
If yes, please describe any needed support as a result of above.

Other relevant historical information necessary to ensure appropriate support:

SECTION VII FINANCIAL INFORMATION

Payment Method:

Med. Waiver/iBudget Medicaid Number: ___________________

GR

CDC

Private Pay *(Please complete payment agreement)*

Financial Assistance *(Please complete scholarship application) (Dependent on funds available & eligibility requirements)*

Other ______________________________

I consent to allow MacDonald Training Center, Inc. (MTC) to request and review additional information/supporting documentation from other providers including WSC, BCBA, Supporting Living and Supported Employment agencies .

____ _____________________________

Signature Date