BiG Great Lakes
1 N O'Plaine Rd
P.O. Box 9031
Gurnee, IL 60031
847-532-5414
www.biggreatlakes.org
biggreatlakes@gmail.com

Application for Admissions

Thank you so much for your interest in BiG Great Lakes. We are very honored to start the journey with you to see what BiG adventures could lie ahead. Please complete and return the following items:

- Application
- Medical History
- Release of Information
- Recent family photo and individual photo
- Your application fee of $50. Checks should be made out to Big Great Lakes and mailed to the address above. Please write "application fee" on the check memo.

Please answer all questions as thoroughly as possible. In addition to these forms, please send any other information that would be helpful in determining whether BiG Great Lakes is the best fit for the applicant.

The Admissions Committee will conduct a thorough assessment of the information provided determining the suitability of each applicant and will notify you after reviewing. If you have any questions, please do not hesitate to call 847-532-5414.

All applicants to BiG Great Lakes must be age 20 or older. Please note that if the applicant is offered a place in the program, there will also be a $250 enrollment fee.

BiG Great Lakes Application for Admissions

Please complete the application in full and return with a recent individual photograph and a family photograph.

I AM APPLYING FOR:		
□ Entrepreneur Vocational Program (opening fall 2021)	□ Residential and vocational program (n/a at this time)	
Requested placement date:		
APPLICANT INFORMATION		
Name:		Birthdate:
Preferred Name:	Home Phone: Cell #	SSN:
Current Address:		
City:	State:	Zip:
Height:	Weight:	Gender: □ Male □ Female
FAMILY INFORMATION/EMERGENCY CONTACTS		
Mother's Name:		
Home Address:		
City:	State:	Zip:
Preferred Email:		
Occupation/Company Name:		
Home Phone:	Cell:	Work:
Father's Name:		
Home Address:		
City:	State:	Zip:
Preferred Email:		
Occupation/Company Name:		
Home Phone:	Cell:	Work:

Legal Guardian Name:	Relationship:	
Home Address:		
City:	State:	Zip:
Preferred Email:		
Occupation/Company Name:		
Home Phone:	Cell:	Work:

EMERGENCY INFORMATION/MEDICAL INSURANCE COVERAGE

Who would you like to be the first person contacted in the event of an emergency?		
Additional Emergency Contact (in addition to parent/guardian):		
Home Phone:	Cell:	Work:

In the event of a transfer (if given an option) is there a hospital preference? If so, which hospital?		
Insurance Company:	Policy Number:	Group Number:
Insurance Company Address:		Insurance Company phone:

FAMILY INFORMATION

Sibling Names	Ages

CURRENT and PAST LIVING ARRANGEMENTS

□ Lives at home □ Currently □ Past (reason for leaving) _____

□ Group/Family Home – CILA □ Currently □ Past (reason for leaving) _____

□ Independent Living Situation □ Currently □ Past (reason for leaving) _____

□ ICF □ Currently □ Past (reason for leaving) _____

PROGRAMS ATTENDED

Check all situations in which the applicant has participated in or currently participating in

□ Social – Recreation Based Day Program	□ Other (please explain)
□ Vocational Work Program	□ Other (please explain)
□ Competitive Employment	□ Other (please explain)
□ Special Olympics	□ Other (please explain)
□ Church/Spiritual Involvement	□ Other (please explain)

PLEASE COMPLETE THE FOLLOWING INFORMATION ON PAST PROGRAMS ATTENDED

Name:		Dates:
Address:		
City:	State:	Zip:
Type of Program (refer to list at top of page):		
Reason for Leaving:		
Person to Contact for More Information:		

Name:		Dates:
Address:		
City:	State:	Zip:
Type of Program (refer to list at top of page):		
Reason for Leaving:		
Person to Contact for More Information:		

Name:		Dates:
Address:		
City:	State:	Zip:
Type of Program (refer to list at top of page):		
Reason for Leaving:		
Person to Contact for More Information:		

SOCIAL SKILLS EVALUATION

EVALUATIONS & ASSESSMENTS

Has the applicant had any of the following? If yes, give name of *the most recent person or agency*.

Psychological Evaluation	□ Yes □ No	Dates:	Person/Agency
Psychological Counseling	□ Yes □ No	Dates:	Person/Agency
Psychiatric Evaluation	□ Yes □ No	Dates:	Person/Agency
Psychiatric Hospitalization	□ Yes □ No	Dates:	Person/Agency
Speech/Language Assessment	□ Yes □ No	Dates:	Person/Agency

QUESTIONS ABOUT THE APPLICANT

Please describe applicant's general health, including special medical problems, diagnosis and/or disabilities:

Please describe applicant's communication abilities:

Please describe applicant's social/emotional state most of the time (for example: withdrawn, hyper-verbal, frustrated, sociable, even-tempered, etc.):

Does he/she prefer to be with peers, family, someone older, younger, or alone? Please explain:

Please describe the applicant's daily routines and leisure (free time) activities:

How do you see the applicant's physical, mental and emotional disabilities?
How does the applicant see their own physical, mental and emotional disabilities?
What are the applicant's special talents, gifts, interests, and/or strengths? (besides being themselves)
Has the applicant ever been involved with any of the following? Tobacco □ Yes □ No Drug Use □ Yes □ No Criminal Activity □ Yes □ No Sexual Activity □ Yes □ No If yes, please explain:
Please describe activity areas and/or situations that the applicant strongly dislikes:
How does the applicant respond to situations they don't like or that upsets them?
What techniques are used to de-escalate behaviors?
Has the applicant ever exhibited behaviors such as hitting, yelling, throwing, biting, pulling hair or making verbal threats, etc? If so, what seems to trigger these behaviors?
Would you consider the applicant to be self-injurious, or harmful to others? If so, please explain. Frequency?

If you answered yes to the above, do you know the triggers of behavior? Medical? Pain? Emotional/Mental? Sensory? Triggers?

Please describe activity areas and/or situations that the applicant enjoys:

Does the applicant require constant at-home supervision? □ Yes □ No

Can the applicant be left at home to function independently? □ Yes □ No If yes, for what period of time? _____

What type of supervision does the applicant require in the community?

What type of supervision does the applicant require in parking lots?

PLEASE CHECK WHICH OF THE FOLLOWING APPLIES TO THE APPLICANT:

□ likes people	□ sensitive to sound
□ gets along well with friends	□ easily frightened
□ follows directions willingly	□ can get easily agitated/irritable
□ shows concern	□ gets anxious
□ tends to be a loner	□ has self-stemming behaviors
□ respects rights & property of others	□ perseverates
□ gets angry easily	□ can introduce self
□ tends to be shy initially	□ forms close relationships
□ sensitive to light	□ is generally happy
□ sensitive to touch	□ other: _____

WHICH OF THE FOLLOWING APPLYS TO THE APPLICANT'S COMMUNICATION SKILLS?

□ speaks fluently and understands fully	□ communicates by writing
□ can make basic wants and needs known	□ can read
□ sign language	□ uses gestures effectively
□ PECS	□ uses a communication device- please describe:
□ RPM	
□ understands short, direct commands	
□ has little to no communication skills	□ other: please describe

SELF-HELP SKILLS

Will an attendant accompany 1:1 The applicant? □ Yes □ No

If so, what is their primary role?

MEALS

□ no assistance needed
□ total assistance needed
□ some assistance needed
□ can use a fork and/or spoon
□ needs a straw for liquid
□ can drink out of a cup independently
□ food needs to be cut/chopped
□ ability to prepare meals
□ able to use microwave independently

Special instructions:

MOBILITY

□ walker
□ braces
□ crutches
□ manual wheelchair
□ electric wheelchair
□ not able to stand for prolonged periods of time
□ unsteady gate
□ can walk but needs assistance
□ has physical limitations that limit participation in Activities:

Special instructions:

SHOWERS

□ no assistance needed
□ total assistance needed
□ some assistance needed
□ helping shampooing hair only

Special instructions:

DRESSING

□ no assistance needed
□ total assistance needed
□ some assistance needed
□ needs help with buttons/zippers/shoes

Special instructions:

TOILETING

□ no assistance needed
□ help transferring
□ help cleaning up
□ wets bed
□ diapers/depends
□ assistance needed only after a bowel movement

Bowel Control □ full control □ limited control □ no control

Bladder Control □ full control □ limited control □ no control

Special instructions:

OTHER SELF CARE			
washing hands	□ needs no help	□ needs some help	□ needs total help
washing face	□ needs no help	□ needs some help	□ needs total help
brushing teeth	□ needs no help	□ needs some help	□ needs total help
cleaning ears	□ needs no help	□ needs some help	□ needs total help
combing hair	□ needs no help	□ needs some help	□ needs total help
trimming fingernails	□ needs no help	□ needs some help	□ needs total help
trimming toenails	□ needs no help	□ needs some help	□ needs total help
using deodorant	□ needs no help	□ needs some help	□ needs total help
shaving	□ needs no help	□ needs some help	□ needs total help
managing menstrual period (if applicable)	□ needs no help	□ needs some help	□ needs total help

SELF – HELP SKILLS Additional comments:

MEDICAL HISTORY

DIAGNOSIS

Primary Diagnosis:	Secondary Diagnosis:

Any other medical diagnosis:

PHYSICIANS & DENTIST

Name of applicant's primary physician:

Address:	Phone:

Date of last physical exam:

Name of applicant's dentist:

Address:	Phone:

Date of last dental exam:

List names of any other specialists who have treated or are treating the applicant:

SPECIALTY	**NAME**	**ADDRESS**	**PHONE #**
NEUROLOGIST:	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS				
Is the applicant on any regular medications or supplements? □ Yes □ No If yes, please list below: (please use an additional sheet if necessary)				
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason::
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason:
Name:	Dosage/Frequency:	Prescribed by:	Date Prescribed:	Reason:
Name:	Dosage/Frequency	Prescribed by:	Date Prescribed:	Reason:

ALLERGIES, RESTRICTIONS, AND SEIZURES
Is the applicant allergic to any medications? □ Yes □ No If yes, please list:
Does the applicant have any other allergies or sensitivities: foods, pollens, insect bites, etc.? □ Yes □ No If yes, describe what allergies/sensitivities, reactions, and what treatment is usually necessary.
Does the applicant have any dietary restrictions? □ Yes □ No (swallowing purposes or food intolerances) If yes, please list: Does the applicant have sensory issues with foods? □ Yes □ No If yes*, favorite foods*: Foods or textures they will not tolerate:

Does the applicant use an Epi Pen? □ Yes □ No If yes, one must be supplied by the participant

If on any medication/injection for allergies, please give name of medication/injection, dosage, and frequency:

HISTORY OF SEIZURES:

Type of Seizure: □ Absent □ Tonic □ A Tonic □ Other_____

Is there an awareness of the seizure before it occurs? □ Yes □ No

If so, please describe.

911 will be called if that is part of your seizure plan or if there are any respiratory issues.

FAMILY HISTORY

Since some conditions can be hereditary, please provide the following information. If any member of the applicant's family has had any of the following conditions or problems, please indicate and identity their relationship to the applicant.

Hypertension	□ Yes □ No	Relationship	**Stroke**	□ Yes □ No	Relationship:
Heart Attack	□ Yes □ No	Relationship	**Kidney Disease**	□ Yes □ No	Relationship:
Diabetes	□ Yes □ No	Relationship	**Gout**	□ Yes □ No	Relationship:
Cancer	□ Yes □ No	Relationship	**Arthritis**	□ Yes □ No	Relationship:
Migraines	□ Yes □ No	Relationship	**Glaucoma**	□ Yes □ No	Relationship:
Epilepsy	□ Yes □ No	Relationship	**Other**	□ Yes □ No	Relationship:

HISTORY OF ILLNESS, HOSPITALIZATION, & SURGERY

Has the applicant had more than a brief illness during the past three years? □ Yes □ No

If yes, when?

Please describe:

Name and address of attending physician:

Has applicant had any surgeries? □ Yes □ No If yes, when?

Describe:

Please list hospital and address:

HEALTH HISTORY

If the applicant is prone to (or has had) problems with any of the following, please indicate YES or NO. If YES, explain in space provided. List preferred treatment if applicable. If extra space is needed, use separate piece of paper

Headaches - Migraines	□ Yes □ No	
Eyes	□ Yes □ No	
Ears/Hearing	□ Yes □ No	
Scoliosis	□ Yes □ No	
Chest Infections	□ Yes □ No	
Asthma	□ Yes □ No	
Epilepsy/Seizures	□ Yes □ No	
Tuberculosis	□ Yes □ No	
Heart Trouble	□ Yes □ No	
Kidney Disease	□ Yes □ No	
Stomach / GI	□ Yes □ No	
Diabetes	□ Yes □ No	
Diarrhea or Constipation	□ Yes □ No	
Fainting Spells	□ Yes □ No	

Menstrual Problems	□ Yes □ No	
Muscle Problems	□ Yes □ No	
Central Nervous System	□ Yes □ No	
Neurological Problems	□ Yes □ No	
Emotional Problems	□ Yes □ No	
Psychological Problems	□ Yes □ No	
Psychiatric Problems	□ Yes □ No	
HIV	□ Yes □ No	
Hepatitis	□ Yes □ No	
Covid-19	□ Yes □ No	
Other	□ Yes □ No	

Please list all childhood diseases (mumps, measles, chickenpox, etc.)

IMMUNIZATION RECORD

Has the applicant received a COVID 19 immunization? □ Yes □ No

If not, would they desire to have one? □ Yes □ No

Has the applicant had any vaccine adverse reactions	□ Yes □ No	Date:

AIDS & DEVICES

Does the applicant use any of the following?

□ Glasses

□ Contacts

□ Hearing Aids

□ Prosthetics

□ Other: _____

ADDITIONAL INFORMATION
If there is any further information you feel should be provided which is a factor and could influence the care, health, and well-being of this individual at BiG Great Lakes, please explain:
What are your least favorite activities? What are your favorite activities? If you are having a hard day, what's the best way for you to recover, feel calm or in control again?

FINANCIAL INFORMATION

Financial		$ Amount		$ Amount
Do you receive:	□ SSI	_____	□ HCBS waiver	_____
	□ PUNS (Home-based) □ PUNS (residential)	_____	□ IRIS	_____
	□ DRS	_____	□ SSDI	_____
	□ Employment Earnings	_____	□ Other	_____

Agency _____ Case Manager _____

Phone _____ Email_____

Have you spoken with your case manager about attending BiG Great Lakes? _____

Individual Income: _____

Family's Household Income (if Parent/Guardian claims you as a dependent on tax return): _____

Do you have Social Security Application Pending? □ Yes □ No

Will you be applying for scholarship to help with program fees? □ Yes □ No

What are your hopes, goals and dreams for the applicant in attending BiG GL?

REFERENCES

Please list three (3) individuals (different from those listed on page 3) who have worked with or known the applicant

Name:	Phone:		
Address:	City:	State:	Zip:
Email:			

Name:	Phone:		
Address:	City:	State:	Zip:
Email:			

Name:	Phone:		
Address:	City:	State:	Zip:
Email:			

APPLICATION SIGNATURES

I affirm that the preceding information is a complete and true statement of all the facts and circumstances relative to this participant's application for enrollment at BiG Great Lake's residential and/or vocational day program.

We, the undersigned, do give our permission for BiG Great Lakes to contact any of the references, programs, schools, and professionals listed on this application.

I also authorize anyone who has any information on this client to release said information they hold on him/her to BiG Great Lakes. Copies of this release may be used to obtain information from anyone listed on application for acceptance into BiG Great Lakes.

Signature of Parent/Guardian: Date:

Signature of Applicant (if appropriate): Date:

If application was filled out by someone other than parent/guardian, please sign below:

Signature: Relationship: Date:

PHOTOGRAPH/IMAGE CONSENT

BiG GL would like your permission to use images/photos that may include your applicant.

I hereby grant permission to BiG GL to photograph and video me, and otherwise capture my image, and to make recordings of my voice. I further grant to BiG GL the right to reproduce, use, exhibit, display, broadcast, and distribute these images and recordings in any media now known or later developed for promoting, publicizing or explaining BiG GL and its activities and for administrative, educational or research purposes. Photographs, video images, and voice recordings are the property of BiG GL.

Signature of Parent/Guardian: _____ Date: _____

Signature of Applicant (If appropriate): _____ Date: _____

BiG Great Lakes CONSIDERS ALL APPLICANTS REGARDLESS OF SEX, RACE, RELIGION, OR ETHNIC ORIGIN.

MEDICAL TREATMENT CONSENT

During volunteer days a Big Great Lakes, we need the following consent signed in case a medical emergency should arise and your applicant need immediate medical care or emergency transport to a hospital.

The Big Great Lakes staff has my consent to obtain medical assistance and treatment for both routine and emergency care for: (name of applicant) _____

Treatment includes but is not limited to the following:

- Ambulance transport to hospital or emergency care facility
- Hospital admission for in-patient care
- Administering of prescribed medications
- X-Rays
- Lab Work

This authorization is valid throughout application process and volunteer days worked in BiG Great lakes.

Signature: _____ Date: _____ Relationship _____