Amos Cottage Therapeutic Day Program
Admission Assessment

Child's Full Name:____
Date of Birth:________________Race:___________Gender: Male or Female
Social Security Number:__________________________

Mother's Name:______________________________Date of Birth:___________
Father's Name:_______________________________Date of Birth:___________
Name and address of person with whom the child resides(include street, city and zip code):____
____
Home phone number:____________________________
Parents:)circle one) Married Unmarried Separated Divorced Widowed
Who has legal custody of child?________________________________

Please list all persons living in child's home and their date of birth:
____
____
____
____

Mother's occupation:__________________Mother's work phone:______________
Mother's employer:_______________________________
Highest school grade completed:___________

Father's occupation:____________________Father's work phone:_____________
Father's employer:________________________________
Highest school grade completed:____________

Birth/Medical History
Were there problems during the pregnancy, labor, or delivery? If so, explain:_____
How many weeks or months was the pregnancy?________Baby's birth weight:_______
Birth was:(please ircle) Normal Cesarea Breech Twins or more
Did baby have problems after birth?________If yes, please explain:_________________
____
Please list any major illnesses or injuries your child has had to this date:______________
Is your child taking any medications regularly? If yes please list below:
____

(over)

Admission Assessment
Page 2

Developmental History
At what age did your child: Roll over_________ Sit Alone___________
Pull up to furniture_________Crawl____________Walk______________
Say single words__________Say 3 word sentences_______________
Become toilet trained____________________________

Referral Concerns
What are your primary concerns about your child?
____
____
What have you been told regarding these concerns? (by your child's doctor, etc..)
____
Has your child received a behavioral or medical diagnosis? If yes please note:
____
Who referred you to the Therapeutic Day Program?____________________________

Please check the areas that you have current concerns about your child:

- ☐ Crawling
- ☐ Walking
- ☐ Running
- ☐ Climbing (play equipment/stairs)
- ☐ Jumping
- ☐ Picking up small objects
- ☐ Drinking from cup
- ☐ Stacking blocks
- ☐ Using a crayon/pencil
- ☐ Using scissors

- ☐ Ability to imitate sounds/words
- ☐ Following simple directions
- ☐ Understanding what you say
- ☐ Saying words
- ☐ Combining words into phrases
- ☐ Speech being understood by others

- ☐ Awareness of others
- ☐ Seeking out others to play
- ☐ Pointing out interests/wants
- ☐ Taking turns during play with others
- ☐ Interest in imitating others
- ☐ Enjoying simple interactions games
- ☐ Using eye-contact appropriately
- ☐ Responding to affection

- ☐ Attention span
- ☐ Ability to remain in seat when needed
- ☐ Being always on the go
- ☐ Not obeying
- ☐ Temper tantrums
- ☐ Talking back

- ☐ Sleep problems
- ☐ Toilet training
- ☐ Hitting, biting, or kicking peers or siblings
- ☐ Hitting, biting, or kicking parent

- ☐ Physical growth
- ☐ Eating skills (i.e., chewing, swallowing)
- ☐ Unusual food preferences
- ☐ Lack of eating
- ☐ Other:
- ☐ Learning what has been taught
- ☐ Remembering things
- ☐ Vision
- ☐ Hearing

Pre-school/School History
Does your child attend daycare, preschool, or school? If yes, list name and address of program and how long has child been enrolled:
____
____
____

Does child receive any special therapies or services (i.e., speech therapy, early intervention, other)? If so explain:
____
____

Does you child have an IEP? Yes☐ No☐
(If your child has an IEP kindly provide the program a copy of the plan)

Do you think your child needs additional services? If so explain:
____
____
____

What would you like to see done for your child during this admission?
____
____

Please complete the following to assist us in obtaining information needed to plan for your child's treatment
Hospital Address of where your child was born:________________________________
____
Child's current doctor and address____
____
Pleas list any other doctors/evaluators who have treated your child and their addresses:
____
____
____
Has your child ever been an inpatient or outpatient at NC Baptist Hospital or Brenner Children's Hospital (If so explain):
____
____

(over)

Please complete the following as it applies to your child:
☐ Medicaid, *Medicaid number is:*______________________
☐ Insurance, is with________________________________

Name of person completing this form:____________________________

I do hereby give my permission at this child's parent or guardian to have him/her treated/evaluated by the Day Treatment Team at Amos Cottage. I understand that this facility is both a service and a training program, and give my consent to have fully supervised students participate in the evaluation.

Parent/Guardian
Signature:_________________________Date:____________________

Kindly fax or mail this form once complete:
Attention: TDP Program Assistant
Fax to (336) 765-0842
Address: 3325 Silas Creek Pkwy
Winston-Salem, NC 27103

Amos Cottage Therapeutic Day Program
3325 Silas Creek Parkway
Winston-Salem, NC 27103

Financial Coverage
(*Please Complete*)

Client's Name ______________________________ Birth date: _________

Social Security Number: _______________________________

1. Is client covered by any **private insurance**? Yes ☐ No ☐

   Policyholders Name: _______________________________

   Employer: _______________________________________

   Name of Insurance Company: ______________________

   Address and Telephone Number: ____________________

   Policy Number: ________________ I.D. number: ________________
   Group Number: ________________
   Claims Address:
   ____

   ____

2. Is client covered by **Medicaid**? Yes ☐ No ☐

   Medicaid Number: ____________________________

3. Is client approved for outpatient services? Yes ☐ No ☐

   Carolina Access Doctor's Name: _______________________________

   Doctor's Carolina Access number (*contact PCP to obtain number)*: ___________

   Mail To:
   Amos Cottage Therapeutic Day Program
   Attention: TDP Program Assistant
   3325 Silas Creek Parkway
   Winston-Salem, NC 27103

Amos Cottage/United Way
Request for Financial Assistance
For Therapeutic Day Program

Client's Name: ____

Parent/Guardian Name: _____________________________________

Number of people in immediate family: ____________

Address: ____

Home Phone #______________________ Work Phone #______________________

Immediate family members in client's household:

Name	Relationship to Client

List all Employers or Source of Income/Reason for None for 12-month period.	Dates: From	To	Yearly Gross Income	Yearly Income After Tax	Documented
		Total Gross Family Income:			
		Fed, State & SS Tax			
		Income after Taxes:			

Total Amount Income after Taxes: $________________

Eligibility for other Programs:
SSI Yes☐ No☐
Medicaid Yes☐ No☐
Medicaid #__________________________
Eligibility Date:______________________
Please complete the entire form; partial completion of form can delay the admission process.

Applicant's Signature____

Relationship to client________________________ Date_____________