association for persons with special needs

APPLICATION FOR ADMISSION TO APSN CENTRE FOR ADULTS

Affix Photo

Please ensure that you fill in all the blanks.

APPLICANT'S INFORMATION

Name of Applicant : _____

Address : _____

_____ Postal Code _____

Date of Birth : _____

Country of Birth : _____ Race: _____

Citizenship : _____ Gender: _____

Contact No. : _____ (H) _____ (Hp)

Email : _____

NRIC/Passport No. : _____ Religion: _____

Language (spoken) : ☐ English ☐ Mandarin ☐Malay ☐Tamil ☐ Others: _____

Language (written) : ☐ English ☐ Mandarin ☐Malay ☐Tamil ☐ Others: _____

EDUCATIONAL BACKGROUND (enclose copies of school results/reports)

Highest standard obtained: _____

Name/s of schools attended: _____

Month/ Year of admission to school: _____

Month / Year of leaving school: _____

Reasons for leaving: _____

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EMPLOYMENT HISTORY (enclose copies of certificates/ testimonies, if available)

From – To	Position(s) Held / Company	Reasons for leaving
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please tick the appropriate boxes and ensure that you answer <u>all</u> the questions.

ACTIVITIES OF DAILY LIVING

I - Independent L - Little Assistance S - Substantial Assistance D - Totally Dependant

					Remarks (if any)
Eating	☐ I	☐ L	☐ S	☐ D	_____
Bathing	☐ I	☐ L	☐ S	☐ D	_____
Dressing/Grooming	☐ I	☐ L	☐ S	☐ D	_____
Toileting	☐ I	☐ L	☐ S	☐ D	_____
Housework	☐ I	☐ L	☐ S	☐ D	_____
Using Telephone	☐ I	☐ L	☐ S	☐ D	_____
Counting Money	☐ I	☐ L	☐ S	☐ D	_____
Reading	☐ I	☐ L	☐ S	☐ D	_____
Reading Time	☐ I	☐ L	☐ S	☐ D	_____
Using Transport	☐ I	☐ L	☐ S	☐ D	_____

MODE OF TRANSPORTATION

How is the applicant expected to travel to CFA?

☐ MRT ☐ Public bus ☐ Private car ☐ Others (Please specify): _____

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MEANS OF COMMUNICATION

☐ Verbal ☐ Written ☐ Others (Please specify): _____

APPLICATION KNOWN TO OTHER AGENCIES

☐ YES ☐ NO

If yes, please state name of agency, contact person and number, reason for referral and the outcome of application/referral:

_____

_____

OTHER INFORMATION

1. Describe the applicant's character and behaviour. Please specify unusual behaviour, if any.

_____

_____

_____

2. What has the applicant been doing before applying for admission to CFA?

_____

_____

_____

3. What are the hobbies / interests / likes and dislikes of the applicant?

_____

_____

_____

4. Other necessary information :

_____

_____

_____

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FAMILY'S INFORMATION

Father's Name (in Full) : _____

Date of Birth : _____ Citizenship: _____

NRIC/Passport No. : _____ Religion: _____

Occupation : _____ Race: _____

Salary (Gross per month) : ☐ below 500 ☐ 501- 1000 ☐1001-2000 ☐2001-3000
☐ 3001-4000 ☐above 4001

Marital Status : ☐ Single ☐ Married ☐ Separated ☐ Divorce ☐ Widowed

Highest Qualification : ☐ Primary ☐ Secondary ☐ A Levels/ Diploma/ ITE
☐ Degree: Bachelors, Masters, Doctorate

Home Address : _____
_____ Postal Code _____

Contact No. : _____ (H) _____ (O) _____ (Hp)

Email : _____

Type of Accommodation : ☐ HDB: Rental ☐ HDB: 3/4/5 rms / Exec ☐Private: _____

Spoken Language at home : ☐ English ☐ Mandarin ☐Malay ☐Tamil ☐ Others: _____

Mother's Name (in Full) : _____

Date of Birth : _____ Citizenship: _____

NRIC/Passport No. : _____ Religion: _____

Occupation : _____ Race: _____

Salary (Gross per month) : ☐ below 500 ☐ 501- 1000 ☐1001-2000 ☐2001-3000
☐ 3001-4000 ☐above 4001

Marital Status : ☐ Single ☐ Married ☐ Separated ☐ Divorce ☐ Widowed

Highest Qualification : ☐ Primary ☐ Secondary ☐ A Levels/ Diploma/ ITE
☐ Degree: Bachelors, Masters, Doctorate

Home Address : _____
_____ Postal Code _____

Contact No. : _____ (H) _____ (O) _____ (Hp)

Email : _____

Type of Accommodation : ☐ HDB: Rental ☐ HDB: 3/4/5 rms / Exec ☐Private: _____

Spoken Language at home : ☐ English ☐ Mandarin ☐Malay ☐Tamil ☐ Others: _____

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If the applicant is being taken care of by someone other than the parents, please fill in the following. *(Please attach a photocopy of the legal guardianship document with this application.)*

Current Care Provider's Name (in Full): _____

NRIC/Passport No. : _____ Relationship: _____

Legal Guardian's Name (in Full): _____

NRIC/Passport No. : _____ Relationship: _____

Occupation : _____ Race: _____

Home Address : _____

_____ Postal Code _____

Contact No. : _____ (H) _____ (O) _____ (Hp)

Email : _____

Particulars of all siblings of applicant in order of birth and other relatives in regular contact with the applicant:

Name	Gender	D.O.B.	Relationship	Occupation
1.				
2.				
3.				
4.				

Check the appropriate boxes and provide brief description (on a separate sheet if necessary):

1. Has the applicant been in trouble with the police/Law? ☐ Yes ☐ No
   (If yes, psychological report and/or social report should provide details)

2. Has the applicant suffered (or currently suffers) from serious medical/psychiatric illnesses? ☐ Yes ☐ No
   (If yes, APSN medical report and/or psychological report should provide details)

3. Has the applicant consumed on a regular basis large quantities of prescription/illicit drugs and/or alcohol? ☐ Yes ☐ No
   (If yes, APSN medical report should provide details)

4. Has the applicant tried to harm himself/herself and/or others? ☐ Yes ☐ No
   (If yes, psychological report and/or social report should provide details)

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THIS SECTION IS TO BE COMPLETED BY EX-APSN CLIENTS ONLY:

Date joined APSN : _____ (mm/yy)

Date left APSN : _____ (mm/yy)

Reason/s for leaving APSN: _____

_____

_____

_____

I hereby certify that the information given above is correct.

Name of parent/guardian/applicant * : _____

Signature & Date : _____

* ***Delete accordingly***

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MEDICAL REPORT FOR ADMISSION TO CENTRE FOR ADULTS

As part of the admission criteria, applicants are required to undergo a ***full medical assessment*** by a qualified medical practitioner. Please fill in the blanks and delete accordingly where indicated by *.

Please attach all the relevant reports that were used as the basis for completion of this section.

Name of Applicant: _____ **Sex: Male / Female**

Date of Birth: _____ **BC/NRIC/Passport No.:** _____

Relevant Birth History and Developmental Milestones (provide significant details):

_____

_____

_____

_____

Past Medical History (provide significant details):_____

_____

_____

_____

_____

Is the applicant currently on medication? ☐ Yes ☐ No
(If yes, please specify the schedule of administration and possible consequences if not medicated)_____ _____

_____

Is the applicant having any side-effects from medication? ☐ Yes ☐ No
(If yes, please give details) _____

Does the applicant have any allergies? ☐ Yes ☐ No
(If yes, please give details) _____

Family History of intellectual disability/psychiatric Illnesses/suicide or attempted suicide/alcohol or drug abuse, if any:

_____

_____

_____

_____

Vision

Has the applicant had a formal vision test? ☐ Yes ☐ No
(If no, please facilitate process, if necessary.)

Does the vision appear to be within normal limits? ☐ Yes ☐ No

(If no, please give details)_____

_____

Please answer below and delete accordingly:

		Does applicant Have this condition? Yes / No*	Does this condition affect applicant's everyday functioning? Yes / No*
R 6 /_____	Squint		
L 6/_____	*Astigmatism*	*Yes / No**	*Yes / No**
	Wears contact lens	Yes / No*	Yes / No*
	Wears spectacles	Yes / No*	Yes / No*
	Long sightedness	Yes / No*	Yes / No*
	Short sightedness	Yes / No*	Yes / No*
	Colour blindness	Yes / No*	Yes / No*

Hearing

Has the applicant had a formal hearing test? ☐ Yes ☐ No
(If yes, please indicate name/type of test and date of test. If no, please facilitate referral for test if necessary.)

Name/type of test: _____ Date: _____

Does the hearing appear to be within normal limits? ☐ Yes ☐ No
(If no, please give details/provide a copy of the test report.)

_____

_____

Right ear drum _____

Left ear drum _____

Wears hearing aid? ☐ Yes ☐ No

Current Physical Examination

Height: _____ Weight: _____ Overweight/Average Weight/Underweight*

Please give comments about the applicant's general health and physical well-being (heart/lungs/abdomen/musculoskeletal system/CNS/level of physical fitness).

_____

_____

_____

_____

_____

Does the applicant have a medical diagnosis? ☐ Yes ☐ No

(If yes, please give details) _____

Name of Diagnosing Person: _____ Date of Diagnosis: _____

Hospital/Agency: _____
(Please provide a copy of the diagnosis report.)

Remarks/Recommendations/Prognosis

_____

_____

_____

_____

Name of Doctor: _____ *Signature:* _____

Date of Examination: _____ Organisation Stamp: _____