**Member Application** Today’s Date / /

Name DOB: / /

Home Address Apt #

City State ZIP County

Home Phone Alt/Cell Phone

e-mail Address

SSN Marital Status: single / married / divorced / widowed / separated

Primary Physician Phone #

Medical Facility Preference € Bay Medical Center € Gulf Coast Hospital

Demographic Information:

€ American Indian or Alaskan Native € Native Hawaiian € White

€ Asian Indian € Asian € Black/African American

€ Hispanic € Mixed Ethnicity € Other

Are you a Veteran? € Yes € No If yes, were you injured while on active duty? € Yes € No

Legal Guardian/Power of Attorney/Caregiver

Phone # Cell #

Diagnosis

Allergies

Referred by:

**Financial Information**

Source of income:

Estimated income per month: Medicare/Medicaid No.:

**Emergency Contact Information**

Name Relationship Phone #

Name Relationship Phone #

**What are your reasons for seeking services from Second Chance?**

€ Improve Skills € Socialization

€ Return to work € Be more active

€ Respite for family or caregiver € Community integration

**Injury History/Eligibility**

What type of brain injury do you have?

€ Traumatic € Epilepsy € Stroke

€ Brain tumor € Infection, meningitis, encephalitis € Aneurysm

€ Hypoxia € Drug or alcohol abuse € Other:

If a traumatic injury, how did injury occur?

€ Car Accident € Fall € Violence

€ Motorcycle Accident € Pedestrian € Bicycle Accident

€ Military Action € Other:

When did injury occur?

Were you in a coma? € YES € NO If yes, how long?

What is the last thing you remember before the injury?

What is the first thing you remember after the injury?

Do you currently experience seizures? € YES € NO If yes, when was the last?

**Medical Information**

In addition to brain injury, what other medical conditions do you experience?

**€** Diabetes€ Kidney disease

€ High blood pressure € Cardiac problems (tachycardia, a-fib, heart attack)

€ Arthritis € Muscular-skeletal problems (fractures, back pain)

€ Overweight or obese € Autoimmune disease (lupus, rheumatoid arthritis)

€ Epilepsy € Mental health – diagnosis:

€ Respiratory (COPD, asthma) € Substance abuse (drugs or alcohol)

€ High cholesterol € Other:

**Physical Limitations**

Check one: € Ambulatory € Non-ambulatory (wheelchair assistance)

List any other assistance devices you use:

**Check all that apply:**

€ Difficulty walking € Tremors or spasticity

€ Balance € Paralysis or weakness

€ No issues

*Comments by interviewer (note level of assistance needed)*:

**Personal Care:**

€ Unable to independently care for personal needs (including transfers)

€ Needs minimal assistance for personal care

 Explanation of needs:

€ Fully able to independently care for personal needs

*Comments by interviewer:*

**Cognitive Limitations**

€ Attention or concentration € Memory

€ Judgment (decision making) € Initiation

€ Multi-step tasks (sequencing) € Problem solving

*Comments by interviewer (note: Ask if member can recall the words flag, green, rose throughout the interview):*

**Language and Speech Limitations**

€ Difficulty speaking € Difficulty writing

€ Difficulty following directions € Difficulty reading

*Comments by interviewer:*

**Limitations with Vision**

€ Difficulty seeing clearly (large print) € Problems with bright light

€ Double vision € Wears glasses

€ Legally blind € Totally blind

*Comments by interviewer:*

**Do you wear hearing aids** € YES € NO

**Emotional/Temperament Limitations**

€ Easily frustrated € Throw or hit

€ Cry easily € Trouble coping

€ Raise voice or yell € Inappropriate language

€ Personality changes € Feel depressed or sad

*Comments by interviewer:*

**Education**

What is the highest level of education reached?

€ Grade school € High school or GED

€ Technical training € Some college

€ Associate degree (2 year) € Bachelors degree

€ Masters degree € Doctorate or professional degree

Are you interested in returning to school? € YES € NO

**Work History**

Are you currently employed? € YES € NO

If yes, where do you work? Hours/week

If no, what was your former occupation?

Do you volunteer? € YES € NO

If yes, where do you volunteer? Hours/week

**Living Situation**

Where do you live?

€ House, condo, townhouse € Apartment

€ Nursing home € Assisted Living Facility

**Who do you live with?**

€ Self € Caregiver

€ Spouse € Parents

€ Sibling € Children

€ Boyfriend/girlfriend € Roommate

Has your living situation changed since your injury? € YES € NO

If yes, how has it changed?

Are you satisfied with your living situation? € YES € NO

If no, why not?

**Transportation**

What is your primary mode of transportation?

€ Drive self € Walk

€ Public transportation (trolley) € Rides from friends/family

€ Bicycle € Bay Area Transportation

Has your mode of transportation changed since your injury? € YES € NO

**Lifestyle**

Do you have any special skills or talents (career, hobbies, travel experience, cooking, sewing, languages,

art, etc)?

Please list pre injury activities and interests?

1.

2.

3.

4.

5.

Please list present activities and interests

1.

2.

3.

4.

5.

Please indicate present activity level.

€ Completely passive activity involvement, dependent on others for participation

€ Needs no prompting and minimal assistance with life skills

€ Maintains life skills independently

*Comments by interviewer:*

Have you ever been convicted of a crime, found guilty, or entered a plea of no contest (nolo contendere), even if adjudication was withheld? € YES € NO

If yes, what charges?

€ County € State € Federal

Probation completed: € YES € NO

Total hours needed:

*Comments by interviewer:*

I have read and answered all the questions to the best of my ability.

Signature of Member Date

This application was completed by

 Name and Address

Relationship to Applicant

Signature Date

*This section to be completed by interviewer/Second Chance staff*

Does the applicant meet critical eligibility requirements? € YES € NO

Comments:

Interviewer Date

€ Approved

€ Approved (placed on waiting list)

€ Disapproved

Executive Director Date

Date Started:

Date/Reason Withdrew:

**Disclosure**

I, , understand that Second Chance of Northwest Florida, Inc., is not a medical facility/program and that there is no nurse here to manage my medication or to treat me in a medical emergency. I know that the staff will do what they can to help me if I should have a seizure or similar problem. I do not count on, or expect them to provide medical treatment.

*This form is valid for the length of my participation in Second Chance unless it is terminated with my permission.*

Signature of Member Date

Signature of Authorized Representative (if member Date

is unable to sign)

Signature of Witness Date

**Medical Information**

 *It is important that Second Chance keeps a current list of medications. Please notify us of any changes.*

Name Date

Primary Physician  Phone

Pharmacy Phone



**Transportation Release Form**

I, , do hereby release Second Chance of Northwest Florida, Inc., and all those offering transportation, including staff and volunteers, from any and all liability so that I may fully participate in outings.

Signature of Member Date

Signature of Authorized Representative (if member Date

is unable to sign)

Signature of Witness Date

**Photo and Statement Release**

I, , authorize Second Chance of Northwest Florida, Inc., to copy, reproduce, or publish my photograph, video, and/or personal statement for the purpose of illustration, advertising, display, audiovisual, and public relations purposes for the exclusive purpose of promoting Second Chance of Northwest Florida, Inc.

Signature of Member Date

Signature of Authorized Representative (if member Date

is unable to sign)

Signature of Witness Date

**Second Chance** of Northwest Florida, Inc.

Criteria for Day-Program Admission and Attendance

* Have a brain injury (traumatic or acquired) and be at least 18 years of age.
* Be capable of meeting personal needs, including taking own medication, or have a personal caregiver or family member to assist them.
* Be able to communicate personal needs with others through speech, signing, assistive devices or a caregiver.
* No use of alcohol or illegal drugs during program hours or displaying effects of having used either prior to coming to the program.
* Use of tobacco products in designated areas only, at designated times.
* Refrain from behaviors that pose a threat to self or others.
* Follow Program Rules.

**Program Rules**

* Sign in and sign out in designated area when you arrive and when you leave for the day.
* 90 day trial period for new members for suitability to the program (Admission and criteria rules and Director’s discretion).
* All members are required to attend their scheduled class days or if unable must notify the Director in advance. Ongoing failure to attend or notify staff of absences in advance could result in termination.
* If there is no opening for the program, applicant will be placed on a waiting list and notified at the earliest time of an opening.
* Personal assistants are allowed and required when the member is unable to care for personal needs.
* Family participation is strongly encouraged.

**The Following Is Not Allowed**

* Alcohol, illegal drugs, lack of attendance without approval of the Director.
* Tobacco products are allowed in designated areas only.
* Physical or verbal violence toward people or property, sexual activity or sexual harassment, weapons, profanity, theft, destruction of property and/or vandalism.

Member Bill of Rights is attached. Signature below signifies understanding of these terms and conditions and intent to comply.

Print Applicant Name Date

Applicant Signature Date

Witness Date

Member Bill Of Rights

Membership Criteria

Program Rules

Second Chance of nwfl.inc.

MEMBER BILL OF RIGHTS

Members have the right to be treated with respect,

Dignity, and integrity

Members have the right to be empowered, self-determined, person-centered with free-choice in a welcoming, belonging atmosphere while attending Second Chance of NWFL, Inc.

Members have the right to be self-governing through the fluidity of the program and will have opportunities to engage in reestablishing and empowering occupation or meaning in life

Members have the right to be a part of Second Chance health and wellness and self- empowerment philosophy

Members have the right to know the membership criteria and program rules

Members have the right to be free from sexual harassment.

Members have the right of privacy and confidentiality

Members have the right to voice their needs, improvements, contributions, grievances and other thoughts to the Improvement Committee

Members have the right to voice their opinion

Members have the right to a smoke free environment, except in designated areas

**Member Needs Assessment**

1. Have you had a physical exam in the last 12 months? € YES € NO

2. Have you had a dental exam or cleaning in the last 12 months? € YES € NO

3. Have you had an eye exam in the last 12 months? € YES € NO

4. For females, have you had a gynecological exam in the last 12 months? € YES € NO

Do you use any type of assistive device? € YES € NO If yes, list devices:

List any other needs that Second Chance may be able to assist with:

What skills/services would you like to receive from Second Chance that would help you to integrate back into the community?

€ Basic living skills (i.e. shopping, dressing, cooking) € Social/Recreational activities

€ Employment training € Fine motor skills

€ Reading comprehension € Short term memory/recall

€ Executive skills € Sequencing activities

€ Other:

Satisfaction with Life Questionnaire

Diener, E., Emmons, R., Larsen, J. & Griffin, S. (1985). The Satisfaction With Life Scale. *J Personality Assessment,* 49(1), 71-75.

Below are five statements with which you may agree or disagree. Using the 1 – 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responses. The 7-point scale is as follows:

1 = strongly disagree 5 = slightly agree

2 = disagree 6 = agree

3 = slightly disagree 7 = strongly agree

4 = neither agree nor disagree

 1. In most ways my life is close to my ideal.

 2. The conditions of my life are excellent.

 3. I am satisfied with my life.

 4. So far I have gotten the important things I want in life.

 5. If I could live my life over, I would change almost nothing.

**Family Needs Questionnaire**

We realize that families of those with brain injuries provide valuable support to these loved ones for a lifetime.

Resources and support are necessary for the well being of all involved.

Second Chance frequently has guests speak on a variety of topics. Are there any topics you would like more information on?

What is the best way to communicate with you?

€ Phone:

€ e-mail:

€ Other:

What other resources would you like more information on?

€ Caregivers € Housing

€ Healthcare professionals € Accessibility and equipment

€ Support groups € Respite care

€ Housekeeping € Disability groups

€ Stress management € Legal advice

€ Financial resources € Self care

Can you provide volunteer time to Second Chance? € YES € NO

If yes, please indicate day/time you are available

€ Monday € Tuesday € Wednesday € Thursday € Friday € Saturday

Times:

What types of service are you interested in providing?

€ Arts/Crafts € Computer lab Assistant

€ Classroom Assistant € Clerical/Office

€ Health Room Assistant € Field Trip Chaperone

€ Hobbies/Travel Volunteer € Storyteller/Book Reader

€ Media Center Assistant € Mentor/Motivator

€ Special Activities (fund raisers) € Reading Tutor

Are you interested in connecting with other caregivers? € YES € NO

If yes, how? € Monthly Covered Dish Dinner

 € Support Group

 € Online resources/discussion boards

 € Other: