MARY LEE FOUNDATION
SOUTHPOINTE
1336 LAMAR SQUARE DRIVE
AUSTIN, TEXAS 78704

APPLICATION FOR ADMISSION

Date of Application _____

Date of Admission _____

I. PERSONAL INFORMATION

Full Legal Name _____

Preferred Name to be used_____

Address_____City _____State_____ Zip_____

Height _____Weight_____ Sex _____ Color of Eyes _____ Hair Color _____

Social Security No. _____ Phone _____

Birthplace_____ Birthday _____ Age _____

Religion_____ Church attends and address (if applicable)_____

_____

Marital Status _____ If applicable, date of Marriage/Divorce_____

Citizenship Status _____

Ethnic Heritage _____ Language Spoken or Understood _____

Identifying Marks_____

Health Insurance and ID #s (Please provide cards)

Primary:_____ ID#_____

Secondary:_____ ID#_____

Children (list names, ages and location)_____
_____
_____

Living situation prior to admission (in family's home/own apartment, etc)_____
_____
_____

Problems encountered with prior living situation _____

Describe present behavioral concerns, known triggers and prevention methods _____

Past Behavioral Concerns _____

II Health Record

Diagnoses and Medical or Mental Health Conditions:_____

Allergies_____

Surgeries_____

Dietary Concerns_____

Psychiatric Care and Hospitalization (including any institutionalization)

Dates	Name of Hospital	Reason for Admission

Does client wear glasses? _____ Date last glasses obtained:_____

Eye Doctor's Name & Address:_____
_____

List other adaptive aids used by the client_____
_____
_____
_____

Date of last Dental Exam: _____ Dentist's Name, Address & Telephone:_____
_____

Describe oral hygiene of client_____
_____

Does the client require any sedation for dental work? If yes, document details_____
_____
_____

Has client been or is client currently under treatment with an Orthodontist? _____If so, is work completed? _____ Orthodontist's Name, Address and Telephone_____
_____

If there is a history of seizures or epileptic disorder, please answer the following questions:
At what age did client experience onset of this disorder?_____

Does client experience Grand Mal Seizures?_____ Petite Mal Seizure?_____ or Both _____

How often does the client experience these seizures?_____

Do seizures occur under any particular circumstances? _____
_____
_____

What was the date (approximate) of last seizure?_____

Please list all doctors and other professionals who currently see and/or treat the client. (Counselor, Psychiatrist, PCP, Support Groups etc.)

Name_____ Nature of Service and Frequency of visits
Address_____ _____
City_____ State_____Zip___ _____

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Address_____ _____

City_____ State_____Zip___ _____

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City_____ State_____Zip___ _____

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Address_____ _____
City_____ State_____Zip___ _____

III Family

Father_____Birth Date_____Birth Place_____
Address_____City_____State_____Zip_____
Area Code_____Phone_____Occupation_____

Mother_____Birth Date_____Birth Place_____
Address_____City_____State_____Zip_____
Area Code_____Phone_____Occupation_____

Marital Status of Both Parents_____

Siblings:

Name_____Sex___Age_____ Marital Status_____
Address_____ City_____State_____Zip_____
Name_____Sex___Age_____ Marital Status_____
Address_____ City_____State_____Zip_____
Name_____Sex___Age_____ Marital Status_____
Address_____ City_____State_____Zip_____
Name_____Sex___Age_____ Marital Status_____
Address_____ City_____State_____Zip_____

Names of Approved Visitors_____

_____

_____

_____

Names of people who should not visit_____

_____

_____

IV. IN CASE OF EMERGENCY CONTACT:

Name_____Address_____City_____State__Zip___

Home Phone_____Bus. Phone_____Relationship_____

V. LEGAL COMPETENCY STATUS

Legal Guardian_____

Power of Attorney_____

Representative Payee for Social Security_____

VI. Financial Arrangements:

A. Income of resident and source (SS, SSI, etc)_____

_____

B. Total Tuition to be paid $1650 per month By Whom_____

C. Spending Money and purchase of supplies and other needed items to be paid by whom_____

_____

D. Medical Bills not covered by insurance to be paid by whom_____

VII. OTHER PROBLEMS OR COMMENTS

_____

_____

VIII. Educational/ Vocational

1. Is client attending school now? _____ Grade/Level _____

   Name and location of school:_____

2. High School Graduate? Yes_____No_____ If no, grade reached:_____

   Name and location of school:_____

   If yes, date of graduation: _____

   GED? Yes_____No_____

   If yes, date obtained:_____

3. College Graduate? Yes_____No_____ If no, level reached (if any):_____

   Name and location of school:_____

   If yes, date of graduation: _____

Training

1. Has client participated in a vocational training program or participated in a job program (DARS, etc)? (If yes, explain, state location and send a copy of evaluation if possible)

_____

_____

2. Was training program successfully completed?_____
   (Please be specific as to areas of success or difficulty)_____
   _____
   _____

3. Competitive Employment

   Is client presently employed? _____(If so, where?) _____
   _____

4. Previous Work History

Employer_____Address_____City_____State_____

Dates of Employment_____Type of work_____Reason for Leaving_____
_____Name of Supervisor_____

Employer_____Address_____City_____State_____

Dates of Employment_____Type of work_____Reason for Leaving_____
_____Name of Supervisor_____

5. Is client interested in seeking employment (if not currently working)? If so, what type of work? What does he/she need to be successful?

_____
_____
_____
_____

6. Transportation & Community Safety- Does this person ride the city bus safely? Are there any community safety concerns? Does he/she need training or any restrictions?

_____
_____
_____
_____
_____

IX. Goals

When was this client's difficulties/diagnoses first noticed, and by whom?
(i.e., teacher, doctor, family)

_____
_____
_____
_____
_____
_____

State the nature of the client's present problems and previous difficulties: (Reason for referral and what assistance he/she will regularly need from staff)

Describe briefly your goals and expectations for the client and what you hope Mary Lee Foundation-Southpointe can accomplish:

Authorization for Emergency Medical Care

To Whom It May Concern:

This is to certify that I, the undersigned, consent to the administration of anesthetics, and the performance of whatever surgical procedure is necessary for _____
(Name of Client)

This Consent is given only to cover those instances, which are considered medical emergencies on the advice of a physician when there is not sufficient time to notify me.

It is also agreed that Mary Lee Foundation may authorize routine medical and dental work, and recommended diagnostic procedures – including electroencephalogram and immunizations.

_____ _____
Date Client Signature

_____
Guardian Signature or Witness

MARY LEE FOUNDATION
SOUTHPOINTE

PHOTO RELEASE FORM FOR PUBLICATION

I, _____ do / do not (please circle) hereby give my consent to the Mary Lee Foundation to take my picture, for use in publications for public educational purposes, and for the Mary Lee Foundation website and Facebook page, with all identifying information deleted.

_____

Client or Guardian Signature

Yes _____ No _____

_____

Date

2800 Single
2200 Double

mary lee foundation

JHCF Placement Agreement

Client name: _____ Date: _____

This agreement is set forth for the benefit of the client, family or guardian, and the Mary Lee Foundation (MLF). The undersigned hereby authorizes MLF to care for the above-named client, to obtain medical care for the client as needed and agrees to the terms and conditions of this agreement.

The financial arrangements are as follows: per month for a single bedroom, to be paid monthly by the 5th. A late charge of $5.00/day will be assessed if payment is not received after the 5th. It is understood that the above rate is for an unfurnished one-bedroom upstairs apartment and includes room, board and limited supervision. You understand that approved miscellaneous expenses (cigarettes, recreational activities, etc.) and any special purchases (clothing, shoes, household items, hygiene supplies, etc.) are your responsibility. In addition, should you select MLF to provide day program activities through its Daybreak program, you agree to pay the rate of $40.00 per day. These activities will be centered on life skills, socialization, community activities, and volunteer activities.

The undersigned agrees to be responsible for all expenses related to medical care and agrees to provide any information that would be necessary for MLF to assist the client in receiving necessary medical attention.

The undersigned agrees to observe all polices related to residing at 1334 Lamar Square Drive, Austin, TX 78704 and understands that if the client/tenant does not follow the program rules, they can be discharged from the program. It is understood that this is not a treatment program; it is a residential program for individuals preparing for independent living. The following are the rules client agrees to follow:

1. No physical violence;
2. No extreme verbal aggression;
3. No drug or alcohol use;
4. No tobacco use in apartments (smoking cigarettes and vaping is permitted in designated area downstairs only);
5. No persons of the opposite sex (excluding family members and staff) in apartment;
6. Residents must be in by curfew 9pm Sunday to Thursday and 10pm Friday and Saturday – Exceptions can be made if resident is working or with family;
7. Residents must check in with staff and sign in and out when leaving and returning to facility;
8. Resident must take all prescribed medications;
9. Resident agrees to follow orders prescribed by his/her physician;
10. Resident must attend necessary medical appointments;
11. Resident must keep apartment clean with assistance of staff;

12. Residents must cooperate with staff requests; and
13. Pay monthly fee on time.

The undersigned agrees to be responsible for the client upon discharge whether the discharge is based on program completion or based on an emergency discharge status. An emergency discharge will call for an immediate or within a twenty-four-hour removal.

This agreement can be modified by MLF with a 30-day written notice and either party may cancel this agreement with a 30-day written notice. Client/tenant may be evicted for non-payment, if non-payment exceeds 2 weeks, unless an accommodation/agreement is made in writing between party responsible for payment and Mary Lee Foundation.

_____ _____

Mary Lee Foundation Representative Signature Date

_____

Printed Name of MLF Representative

_____ _____

Responsible party for ensuring payment Signature Date
(Parent/Guardian/Relative

_____

Printed Name of responsible party

_____

Address of responsible party

_____

Phone Number of responsible party

_____

Email address of responsible party

_____ _____

Agreed to by tenant/client Signature Date

_____

Printed Name of tenant/client

SOUTHPOINTE

A DIVISION OF THE

MARY LEE FOUNDATION

ATTENTION: JHCF CONSUMERS

Resident's Name: _____

Date: _____

The rules of the JHCF program were set to protect all residents who live here. When residents do not follow the rules, it can put everyone in an unsafe situation. Rules such as being in and staying inside your apartment at curfew, taking all prescribed medications, exiting grounds without notifying staff or signing out and not returning when scheduled are in place for your safety.

Not following these and other rules can lead to discharge from the JHCF program.

I understand the above statement and agree to follow all Mary Lee Foundation rules:

_____ _____

Resident Signature & Date MLF Representative

1339 Lamar Square Drive • P.O. Box 3174 • Austin, Texas 78764 • 512-443-5777 • Fax 512-444-9949