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Please read this packet thoroughly.

ADMISSION CONSIDERATIONS

The University of Michigan Aphasia Program (UMAP) is open to adults 16 and over with all types of aphasia and all levels of impairment. Clients enrolled without a caregiver must be independent in mobility and self-care.

The University of Michigan, as an equal opportunity/affirmative action employer, complies with all applicable federal and state laws regarding nondiscrimination and affirmative action, including Title IX of the Education Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973. The University of Michigan is committed to a policy of nondiscrimination and equal opportunity for all persons regardless of race, sex*, color, religion, creed, national origin or ancestry, age, marital status, sexual orientation, disability, or Vietnam-era veteran status in employment, educational programs and activities, and admissions. Inquiries or complaints may be addressed to the Senior Director for Institutional Equity and Title IX/Section 504 Coordinator, Office for Institutional Equity, 2072 Administrative Services Building, Ann Arbor, Michigan 48109-1432, 734.763.0235, TTY 734.647.1388. For other University of Michigan information call 734.764.1817.

*Includes discrimination based on gender identity and gender expression.

If you have questions about the application process or if you would like to schedule a tour of the Center, please contact our Clinical Services Manager, Ms. Mimi Block, at 734.764.8440. The information gathered on the following forms will help our staff determine suitability to the program.

ADMISSION PROCEDURE

Complete and return the enclosed application. All information will be considered confidential and is protected by Health Insurance Portability and Accountability Act of 1996 (HIPAA). Admission is contingent upon the receipt of your application. Have your physician complete the Medical Information Form.

When your application is received by the Center, records of hospitalization and rehabilitation services will be requested from the information you provide in your application. If you have copies of these records, forward them along with your application to expedite the application process.

The Clinical Services Manager will review the submitted information and determine the candidate's appropriateness for enrollment in UMAP.

Invitations are extended only after receipt and review of the completed application.

The business office at UCLL can answer financial questions.

Enrollment is provided on a first-come-first-served basis in response to the invitation.

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APPLICATION

(All information will be considered confidential)

IDENTIFYING INFORMATION

Name of Applicant _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Date of Birth _____ Age _____ Sex: Male ___ Female _____

Have you applied to this program before? _____ If yes, when? _____

Preferred dates of attendance _____

Name of person completing this form _____

CAREGIVER INFORMATION

Name _____

Relationship to Applicant _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Will you be attending the entire 6-week session with your family member? _____

Would you be interested in attending a weekly family support group? _____

Would you be interested in participating in a weekly caregiver book club? _____

PERSONAL AND FAMILY HISTORY

Marital Status _____

Spouse's Name _____

Spouse's Occupation _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

LANGUAGE SKILLS

It is helpful to understand as much as possible about your communication abilities prior to attending the program. This information allows us to prepare your treatment program.

Please describe your language skills _____

Please check all that apply:

- Speaks in single words
 - phrases
 - sentences
- Formulates questions
- Carries on conversations
- Comprehends single words
 - yes/no questions
 - wh-questions
 - conversations
- Reads single words
 - newspapers
 - novels
- Writes name
 - single words
 - sentences

MEDICAL HISTORY

Nature of Illness/Accident _____ Date _____

Were you unconscious? _____ If yes, for how long? _____

Were you paralyzed? _____ If yes, where? _____

Were you right or left handed before the present problem? _____

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We would like to gather as much information as possible about your condition. Please identify each treatment facility you have attended. Please specify acute care hospital, rehabilitation hospital, or other.

Name _____

Address _____

Type of Treatment Facility _____

Name _____

Address _____

Type of Treatment Facility _____

Name _____

Address _____

Type of Treatment Facility _____

Name _____

Address _____

Type of Treatment Facility _____

Name _____

Address _____

Type of Treatment Facility _____

Please have your doctor fill out the enclosed Medical Information Form.

PERSONAL NEEDS

Are you on any special diet? _____ If yes, please describe _____

Do you have any allergies? _____ If yes, please describe _____

Can you take your medication independently? _____

Would you like medication reminders? _____

Do you use a hearing aid? _____ If yes, please describe _____

Can you walk independently? _____ If yes, please describe _____

Do you use a wheelchair? _____ If yes, please describe _____

Are you independent with your bathroom? _____ If no, please describe _____

Are you able to follow a schedule without direct supervision? _____

Are you able to manage your time without direct supervision? _____

PERSONAL INTERESTS

Knowing your interests helps us to plan your therapy. It does not bare on our decision to accept you into the program.

Please describe 3 previous jobs _____

Please describe 2 - 3 special hobbies _____

Please describe 2 - 3 activities you enjoy doing _____

Please list 2 - 3 books you would like to read _____

Please list your family members and their respective ages _____

HISTORY OF OTHER SERVICES

As we are planning treatment it is helpful to have as much information as possible about the other services you have received.

SPEECH-LANGUAGE EXAMINATION/THERAPY

Professional's Name _____

Agency Name _____

Address _____

Phone (____) _____ Dates Attended _____

PSYCHOLOGICAL TESTING/COUNSELING

Professional's Name _____

Agency Name _____

Address _____

Phone (____) _____ Dates Attended _____

VOCATIONAL TESTING/COUNSELING

Professional's Name _____

Agency Name _____

Address _____

Phone (____) _____ Dates Attended _____

EDUCATIONAL HISTORY

Please indicate the highest level of education you attained.

- Less than 12 years
 - Partial high school (10th or 11th grade)
 - Junior high school (9th grade)
 - Less than 7th grade
- High school graduate
- More than 12 years, but not a college graduate
- College graduate
- Advanced degree

Please name the educational institution you most recently completed _____

Is English your native language? _____ If no, what is your native language? _____

Please indicate the highest level of education attained by spouse.

- Less than 12 years
 - Partial high school (10th or 11th grade)
 - Junior high school (9th grade)
 - Less than 7th grade
- High school graduate
- More than 12 years, but not a college graduate
- College graduate
- Advanced degree

EMPLOYMENT HISTORY

What was your most recent occupation? _____

Who was your most recent employer? _____

Where was the company located? _____

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MEDICAL INFORMATION FORM

(To be completed by physician)

The University of Michigan Aphasia Program (UMAP) offers intensive intervention programs for adults with speech and language difficulties due to brain injury. Each client receives three hours of individual therapy and one hour of group therapy daily. In addition, the program may be supplemented with daily homework and computer activities.

Although the program is self-contained in one building, clients must move from session to session, use an elevator, and be able to care independently for their needs.

Patient Name _____

Date of Birth _____

Date of Onset _____

Etiology of Communication Impairment _____

Medications	Dosage	Frequency

Allergies _____

Other Conditions (please circle):

Hemiparesis

Hypertension

Heart Disease

Syncope

Ulcers

Seizures

Diabetes

Chronic Headaches

Visual Field Deficits

Other Conditions _____

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MEDICAL INFORMATION FORM

Dietary Restrictions _____

Date of Last Completed Physical Exam _____

Do you see this patient routinely?	Yes	No
Do you feel your patient would be physically capable of participating in an intensive speech-language program?	Yes	No
Would you recommend that your patient participate in an intensive speech-language program?	Yes	No
Would your patient require any medical monitoring if involved in our program?	Yes	No
If yes, please describe _____		

Physician's Signature _____

Physician's Name (print) _____

Address _____

Phone _____

Email _____

Date _____

Physician's NPI# _____

Thank you. A copy of the final report will be forwarded to you after appropriate release forms have been signed.