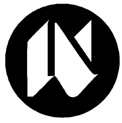


North Memorial Medical Center
3300 Oakdale Avenue North
Robbinsdale, MN 55422-2900
Phone (763) 520-1900

# INTENSIVE APHASIA PROGRAM APPLICATION

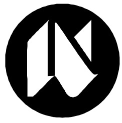


***(All information will be considered confidential)***

**Date**____________________

| **APPLICANT INFORMATION** | | | |
|---|---|---|---|
| Name | | | |
| Nickname | | | |
| Date of birth | Age | SS# - - | Gender ☐M ☐F |
| Address | | | |
| City | State | Zip Code | |
| Home Phone ( ) | Work/Alternate Phone ( ) | | |
| Cell Phone ( ) | Email Address | | |
| Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner | | | |
| Do you need an interpreter? ☐ Yes ☐ No If yes, what kind? | | | |
| What is your ethnicity? ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Prefer not to say | | | |
| What is your race? ☐ White ☐ Black/African American ☐ Asian ☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific ☐ Prefer not to say | | | |
| What is your religious preference? ________________________________ | | | |

| **PHYSICIAN INFORMATION** | | |
|---|---|---|
| **Physician's** Name | Clinic | |
| Address | | |
| City | State | Zip Code |
| Phone ( ) | Fax ( ) | |
| **Neurologist's** Name | Clinic | |
| Address | | |
| City | State | Zip Code |
| Phone ( ) | Fax ( ) | |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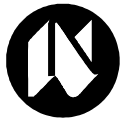
# INTENSIVE APHASIA PROGRAM APPLICATION



| **Emergency Contact/Next of Kin** | | | | |
|---|---|---|---|---|
| Emergency Contact: | | Relationship to Patient: | | |
| Home Phone ( ) | Work/Alternate Phone ( ) | | Cell Phone ( ) | |
| Street Address | | City | State | Zip Code |
| Next of Kin: | | Relationship to Patient: | | |
| Home Phone ( ) | Work/Alternate Phone ( ) | | Cell Phone ( ) | |
| Street Address | | City | State | Zip Code |
| **INSURANCE INFORMATION** | | | | |
| Does your insurance policy require prior authorization? ☐ Yes ☐ No | | | | |
| Primary Insurance: | | | | |
| Member ID #: | Group # | | Effective Date: | |
| Subscriber Name (Name on card): | | | | |
| Subscriber ID #: | | Subscriber Date of Birth: | | |
| Subscriber Social Security #: - - | | Subscriber Employment Status: | | |
| Subscriber Employer: | | Subscriber Employer Phone Number: | | |
| Subscriber Employment Address: | | | | |
| City | | State | | Zip Code |

| Secondary Insurance: | | | |
|---|---|---|---|
| Member ID #: | Group # | | Effective Date: |
| Subscriber Name (Name on card): | | | |
| Subscriber ID #: | | Subscriber Date of Birth: | |
| Subscriber Social Security #: - - | | Subscriber Employment Status: | |
| Subscriber Employer: | | Subscriber Employer Phone Number: | |
| Subscriber Employment Address: | | | |
| City | | State | Zip Code |



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# INTENSIVE APHASIA PROGRAM APPLICATION



## EDUCATIONAL HISTORY

Check highest grade completed in school ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did you attend a university? ☐ Yes ☐ No Degree received:

Is English your native language? ☐ Yes ☐ No

How would you rate your English proficiency? ☐ Poor ☐ Fair ☐ Good/Native ☐ Superior

Were you ever fluent in any other foreign language? ☐ Yes ☐ No

If yes, what language?

## EMPLOYMENT HISTORY

| Current or Most Recent Occupation | Employer |
|---|---|

Are you still employed? ☐ Yes ☐ No

If no, are you on a leave of absence? ☐ Yes ☐ No How long?

## PERSONAL CARE

| | |
|---|---|
| Are you on any special diet?<br>☐ Yes ☐ No | If yes, please describe |
| Do you have any allergies?<br>☐ Yes ☐ No | If yes, what are they? |
| Do you regularly use a wheelchair<br>☐ Yes ☐ No | If yes, are you independent in all transfers?<br>☐ Yes ☐ No |

How far can you go independently (walking or wheelchair)?
☐ 25 yards or less ☐ 25 – 50 yards ☐ 50 – 100 yards ☐ 100 yards or more

| | |
|---|---|
| Are you able to follow a schedule without direct supervision? ☐ Yes ☐ No | Are you able to manage your time without direct supervision? ☐ Yes ☐ No |

## SPEECH/LANGUAGE EXAMINATION/THERAPY

| | | | |
|---|---|---|---|
| Agency 1: | Phone: ( ) | | |
| Street Address | City | State | Zip Code |
| Dates: | | | |
| Agency 2: | Phone: ( ) | | |
| Street Address | City | State | Zip Code |
| Dates: | | | |

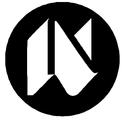
## SPEECH AND LANGUAGE HISTORY

Did you have any speech or hearing problems before this illness/accident occurred? ☐ Yes ☐ No

If yes, describe:

Is there any history of speech, language or hearing problems in your family? ☐ Yes ☐ No

Preferred dates of attendance



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**INTENSIVE APHASIA PROGRAM APPLICATION**


| **COMMUNICATION SKILLS** |
|---|
| What is your primary communication modality? (check one)<br>☐ Speaking ☐ Gestures ☐ Writing ☐ Drawing ☐ Communication Device |
| How do you speak, primarily? (check one)<br>☐ Single words ☐ Phrases ☐ Sentences ☐ Paragraphs |
| Can you formulate sentences and/or questions? ☐ Yes ☐ No |
| Can you understand yes/no questions? ☐ Yes ☐ No |
| Can you follow simple commands, (e.g. "go get the broom") ☐ Yes ☐ No |
| Can you follow conversations? ☐ Yes ☐ No |
| Do you understand what you read? ☐ Yes ☐ No |
| Can you read the following: (check all that apply)<br>☐ Simple words ☐ Short sentences ☐ Newspapers ☐ Books |
| Can you ☐ write, ☐ print, and/or ☐ type your name? (check all that apply) |
| Can you fill out forms? ☐ Yes ☐ No |
| Do you write short messages, (e.g. "call your mom")? ☐ Yes ☐ No |
| Do you use your non-preferred hand when writing and/or drawing? ☐ Yes ☐ No |
| What do you want to achieve from the Intensive Aphasia Program? |
| What is your goal? |

**Please have your doctor complete the enclosed *Medical Information Form***