

**NEW BEGINNINGS ENTERPRISES, INC.**  
**BASIS Assessment Screening**  
**Information Request**

Please fill out the information below and on the back and return these sheets to:

BASIS Assessment Screener  
New Beginnings Enterprises, Inc.  
1001 Wilson-P.O. Box 344  
Neodesha, KS 66757

**PART 1**          Applicant Information

NAME OF APPLICANT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_ MEDICAID NUMBER \_\_\_\_\_  
PARENT/GUARDIAN \_\_\_\_\_  
PARENT/GUARDIAN ADDRESS \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

Please list those professionals who can give the most recent information about the applicant's disabilities. List their name, address, and phone number under the appropriate category. Fill out releases and ask each person listed in this section to send the information to us:

Audiologist \_\_\_\_\_  
Dietitian \_\_\_\_\_  
Neurologist \_\_\_\_\_  
Physical Therapist \_\_\_\_\_  
Occupational Therapist \_\_\_\_\_  
Speech Therapist \_\_\_\_\_  
Social Worker \_\_\_\_\_  
Other (gastro-intestinal specialist, cardiologist, etc.) \_\_\_\_\_  
\_\_\_\_\_

**Other Respondents**

Please list other professionals who have worked with the applicant and have knowledge of behavior and daily functioning levels. List their name, address, and phone number under the appropriate category. They may be contacted by phone or asked question during the interview phase of screening, so please fill out releases and give to each of the persons listed in this section so they will feel free to discuss the applicant's case.

School Personnel \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Day/Residential Programming \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(OVER)

Other (family members, care givers, etc.,-use separate page if needed)

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Current Medication List for MR/DD Services

Please indicate all prescription medication and non-prescription medications currently being taken by the individual:

MEDICATION	DOCTOR	PURPOSE	DOSAGE	FREQUENCY

Once we have received the information from the persons listed, we will contact you for an interview. The interview will be conducted in our office at 1001 Wilson, Neodesha, Kansas, during business hours or scheduled to your convenience.

For the interview, please bring verification of the applicant's social security number, Medicaid number, legal name, and date of birth.

Person providing the information: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the individual applying: \_\_\_\_\_

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For Office Use Only:

BASIS Scheduled For:

Date/Day: \_\_\_\_\_

Time: \_\_\_\_\_

Location: \_\_\_\_\_

Screener: \_\_\_\_\_

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