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| **Hinweise zum Anmeldeformular:**   * Ihre Angaben werden vertraulich behandelt. Sie fallen unter die berufliche Schweigepflicht. * Bei Fragen stehen wir gerne zur Verfügung. |

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| **Name:** | |  | | | | | | | |  | | **Vorname:** | | | | | |  | | | | | | | |
| Strasse: | |  | | | | | | | |  | | PLZ / Ort: | | | | | |  | | | | | | | |
| Geb.-Datum: | |  | | | | | | | |  | | Tel. Privat: | | | | | |  | | | | | | | |
| Konfession: | |  | | | | | | | |  | | Mobil: | | | | | |  | | | | | | | |
| Soz.-Vers.-Nr.: | |  | | | | | | | |  | | Zivilstand: | | | | | |  | | | | | | | |
| Krankenkasse: | |  | | | | | | | |  | | Krankenvers.-Nr.: | | | | | |  | | | | | | | |
| Heimatort: | |  | | | | | | | |  | | Nationalität: | | | | | |  | | | | | | | |
| Schriften in: | |  | | | | | | | |  | | (Bei Ausländern) Bewilligung: | | | | | | | | | | |  | | |
| (Gemeinde, in welcher die Schriften hinterlegt sind) | | | | | | | | | |  | | **(Der Anmeldung ist eine Kopie der Ausländerbewilligung beizulegen.)** | | | | | | | | | | | | | |
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| **Eltern bzw. nächste Familienangehörige bzw. nächste Bezugsperson:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name/Vorname: |  | | | | | | | | | | Bezeichnung der Verwandtschaft / Beziehung: | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | Tel. P: | | |  | | | | | | | | | | Mobil: |  |
| Strasse: |  | | | | | | | | | | Tel. G: | | |  | | | | | | | | | | | |
| PLZ / Ort: |  | | | | | | | | | | E-Mail: | | |  | | | | | | | | | | | |
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| **Beistandschaftliche Massnahme:** | | | | | | | | | **Bemerkungen / Ergänzungen:** | | | | | | | | | | | | | | | | |
| Umfassende Beistandschaft | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Vertretungsbeistandschaft | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Begleitbeistandschaft | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Mitwirkungsbeistandschaft | | | | | | | | |  | | | | | | | | | | | | | | | | |
| keine beistandschaftliche Massnahme | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **(Der Anmeldung ist eine Kopie der Verfügung der Massnahme beizulegen.)** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Wenn Beistand / Beiständin:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name/Vorname: | | | |  | | | | | | | | | | | Tel. G: | | | | | | |  | | | |
| Behörde: (Berufsbeistände) | | | |  | | | | | | | | | | |  | | | | | | |  | | | |
|  | | | |  | | | | | | | | | | | Tel. P | | | | | | |  | | | |
| Strasse: | | | |  | | | | | | | | | | | Mobil: | | | | | | |  | | | |
| PL/ / Ort: | | | |  | | | | | | | | | | | E-Mail: | | | | | | |  | | | |
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| **Aktuelle Wohnsituation:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Eltern / Angehörige | | | | | | | selbständige Wohnsituation | | | | | | | | | | | | | | | | | | | | | |
| Wohnheim | | | | | | | Schulheim | | | | | | | | | | | | | | | Spital / Klinik | | | | | | |
| IV-Massnahme Wohnen | | | | | | | andere Wohnsituation: | | | | | | | | | |  | | | | | | | | | | | |
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| Bezeichnung (Institution): | | | | | | | Adresse: | | | | | | | | | | | | | | zuständige Person: | | | | | | | |
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| **Frühere Wohnsituationen / Heimaufenthalte:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bezeichnung: | | | | | | | | | Adresse: | | | | | | | | | | | | zuständige Person: | | | | | | | |
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| **Aktuelle Tagesstruktur:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Schule  Tagesstätte  geschützte Werkstätte | | | | | | | | | | | | | | | | | | | | | | | | | | |
| im ersten Arbeitsmarkt tätig  IV-Massnahme berufl. Eingliederung  Spital / Klinik | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bezeichnung (Institution): | | | | | | | Adresse: | | | | | | | | | | | | zuständige Person: | | | | | | | |
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| **Frühere Tagesstrukturen:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bezeichnung: | | | | | | | Adresse: | | | | | | | | | | | | zuständige Person: | | | | | | | |
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| **Diagnose, Allergien, notfallrelevante Operationen:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Im Notfall zu beachten:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Vertretungsberechtigte Person im medizinischen Notfall:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name/Vorname: | | |  | | | | | | | | | | Tel.: | | | |  | | | | | | | | |
| Adresse: | | |  | | | | | | | | | | Mobil: | | | |  | | | | | | | | |
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| Zur Zeit **behandelnder Arzt / Facharzt**, der uns ggf. Auskunft erteilen könnte: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name/Vorname: | | |  | | | | | | | | | | Tel.: | | | |  | | | | | | | | |
| Adresse: | | |  | | | | | | | | | | Mobil: | | | |  | | | | | | | | |
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| Zur Zeit **behandelnder Psychiater / Psychologe**, der uns ggf. Auskunft erteilen könnte:: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name/Vorname: | | |  | | | | | | | | | | Tel.: | | | |  | | | | | | | | |
| Adresse: | | |  | | | | | | | | | | Mobil: | | | |  | | | | | | | | |
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| **Einkünfte:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IV-Rente:** | | | | | ganze Rente  Dreiviertelsrente  halbe Rente  Viertelsrente  keine IV-Rente  angemeldet  **(Dem Anmeldeformular ist eine Kopie der Rentenverfügung beizulegen.)** | | | | | | | | | | | | | | | | | | | | |
| **Hilflosenentschädigung:** | | | | | keine  leicht (Aufenthalt im Heim)  mittel (Aufenthalt im Heim)  schwer (Aufenthalt im Heim)  leicht (Aufenthalt zu Hause)  mittel (Aufenthalt zu Hause)  schwer (Aufenth. zu Hause)  (**Der Anmeldung ist eine Kopie der Verfügung über den HE-Anspruch beizulegen.)** | | | | | | | | | | | | | | | | | | | | |
| **Andere Einkünfte:** | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **Gewünschter Wohn- und/oder Tagesstättenplatz:** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Wohnheim** | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **Tagesstätte** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Bemerkung zum gewünschten Wohn- und/oder Tagesstättenplatz:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Gewünschtes Eintrittsdatum:** | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| **Es wird Unterstützung benötigt bei:** | | | | | | | | | | | | | | | | | **Andere Merkmale:** | | | | | | | | |
|  | | | | | | | Kommunikation | | | | | | | | | |  | | | | kann lesen | | | | |
|  | | | | | | | Unterstützter Kommunikation | | | | | | | | | |  | | | | kann schreiben | | | | |
|  | | | | | | | Essen | | | | | | | | | |  | | | | nonverbale Kommunikation mit: | | | | |
|  | | | | | | | Trinken | | | | | | | | | |  | | | |  | | | | |
|  | | | | | | | Körperpflege / Duschen / Bad | | | | | | | | | |  | | | | Rollstuhl | | | | |
|  | | | | | | | An-/Auskleiden | | | | | | | | | |  | | | | gehbehindert | | | | |
|  | | | | | | | Toilette | | | | | | | | | |  | | | | kann beide Hände gut gebrauchen | | | | |
|  | | | | | | | Zähneputzen | | | | | | | | | |  | | | | kann Hände nur teilweise benützen | | | | |
|  | | | | | | | Freizeitaktivität | | | | | | | | | |  | | | | Inkontinenz | | | | |
|  | | | | | | | Benützung öffentlicher Verkehr | | | | | | | | | |  | | | | hörbehindert | | | | |
|  | | | | | | | Orientierung im Gebäude | | | | | | | | | |  | | | | sehbehindert | | | | |
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| **Psychische/soziale Merkmale:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | liebt das Gruppenleben | | | | | | | | | | | | | |  | | | | ist aggressiv: | | | | | | |
|  | | | | | ist eher Einzelgänger: | | | | | | | | | | | | | |  | | | | bei bestimmten Situationen | | | | | | |
|  | | | | | kann sich gut selbst beschäftigen | | | | | | | | | | | | | |  | | | | gegen Sachen | | | | | | |
|  | | | | | ist oft niedergedrückt (depressiv) | | | | | | | | | | | | | |  | | | | gegen Menschen | | | | | | |
|  | | | | |  | | | | | | | | | | | | | |  | | | | gegen sich selbst | | | | | | |
|  | | | | | | Verhalten, das besonderer Betreuung bedarf: | | | | | | | | | | | | | | | | | | | | | | | |
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| **Es wird regelmässig benötigt:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | ärztliche Betreuung | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | Physiotherapie | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | Anderes: | | | | | |  | | | | | | | | | | | | | | | | | | |
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| **Regelmässige Medikamente:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | ja  nein | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Wenn ja: **Medikament / Dosis / Verabreichungsform** | | | | | | | | | | | | | | | | | | | | | | |
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| **Wie sieht die weitere Entwicklung aus?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| noch grosses Entwicklungspotential | | | | | | | | | | | | | | | Zustand stabil | | | | | | | | | progressiver Verlauf | | | | | |
|  | | | | **Bemerkung:** | | | | | | | | | | | | | | | | | | | | | | | |
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| **Was ist mir noch wichtig mitzuteilen?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Ich habe / Wir haben das Anmeldeformular vollständig und wahrheitsgetreu ausgefüllt:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ort / Datum: | | | | | | | | | |  | |  | | | | Unterschrift BewerberIn: | | | | | | | | |  | | | |
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| Ort / Datum: | | | | | | | | | |  | |  | | | | Unterschrift Beistand/Beiständin: | | | | | | | | |  | | | |
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| **Dem Anmeldeformular liegen bei:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Kopie Rentenverfügung | | | | | | | | | | | | | |  | | | Kopie Ausländerbewilligung | | | | | | | |
|  | | | Kopie Verfügung Hilflosenentschädigung | | | | | | | | | | | | | |  | | | Kopie Schriftenempfangsschein | | | | | | | |
|  | | | Kopie Verfügung Beistandschaftliche Massnahme | | | | | | | | | | | | | |  | | |  | | | | | | | |
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**Ablage:** bei Aufnahme in Zentralakte