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| **Today’s date**                                |
| Part I. General information  |
| Consumer |
| First name       | Initial       | Last name       |
| Date of birth       | Age today       | Social Security number       |
| Phone (home)       | Phone (work)       | Phone (cell)       |
| Email Address       | U.S. citizen [ ]  Yes [ ]  No       Country of origin |
| Street       | Apartment/building       |
| City       | State       | Zip code       |
| Primary Diagnosed Disability      |
| Representative |
| First name       | Initial       | Last name       |
| Phone (home)       | Phone (work)       | Phone (cell)       |
| Email Address       |  |
| Street       | Apartment/building       |
| City       | State       | Zip code       |
| Relationship to consumer       | Social Security number       |
| Legal guardian of consumer  [ ]  Yes [ ]  No  | If no, please complete this section, if applicable: |
|  | Legal guardian name       |
|  | Legal guardian address       |
|  | Legal guardian phone (home)      (work)      (cell)      |

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| Family & Other Important People in Consumer’s Life |
| Name       | Age       |
| Address       |
| Phone       | Email       |
| Relationship       |
| Name       | Age       |
| Address       |
| Phone       | Email       |
| Relationship       |
| Name       | Age       |
| Address       |
| Phone       | Email       |
| Relationship       |
| Name       | Age       |
| Address       |
| Phone       | Email       |
| Relationship       |
| Name       | Age       |
| Address       |
| Phone       | Email       |
| Relationship       |
| Name       | Age       |
| Address       |
| Phone       | Email       |
| Relationship       |

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| Current Employment |
| Company       | Address       |
| Supervisor       | Sup phone       |
| Type of work       | Hours per week       | Start date       |
| Transportation       |
| Current Volunteer Work |
| Organization       | Address       |
| Supervisor       | Sup phone       |
| Type of volunteer work       | Hours per week       | Start date       |
| Transportation       |
| Financial Information |
| Income  |  | Expenses |
| [ ]  Jobs | Amount       | [ ]  Rent | Amount       |
| [ ]  Social Security | Amount       | [ ]  Medical bills | Amount       |
| [ ]  Supplemental Security Income (SSI) | Amount       | [ ]  Food | Amount       |
| [ ]  Social Security Disability Income (SSDI) | Amount       | [ ]  Utilities | Amount       |
| [ ]  Food stamps/SNAP | Amount       | [ ]  Other | Amount       |
| [ ]  Supportive living | Amount       | [ ]  Other | Amount       |
| [ ]  Court settlement | Amount       | [ ]  Other | Amount       |
| [ ]  Other       | Amount       | [ ]  Other | Amount       |
| Checking/Savings Accounts |
| [ ]  Checking account  | Bank       | Amount       |
|  | Address        | Phone       |
| [ ]  Savings account  | Bank       | Amount       |
|  | Address        | Phone       |
| [ ]  Other       | Company       | Amount       |

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| Social Behavior |
| What things does the consumer enjoy doing?       |
| What is the consumer’s religious preference?       |
| Does the consumer smoke cigarettes?       |
| Does the consumer drink alcoholic beverages?       |
| How does the consumer feel about being touched (handshake, pat on back, etc.)?       |
| What things make the consumer afraid?      |
| What things make the consumer uncomfortable?      |
| What are some things that help the consumer feel calm or safe during times of unease or anxiety?       |
| How does the consumer express anger or frustration?       |
| Does the consumer run away?       |
| Is the consumer abusive toward him or herself?       |
| Is the consumer abusive toward others?       |
| Does the consumer destroy property?       |
| Does the consumer socialize with peers?       In what ways?       |
| Please describe the personality of the consumer.       |
| Please comment on any other likes or dislikes of the consumer.       |

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| Part II. Current status of consumer |
| Disabilities |
| ***IMPORTANT:* Please state PRIMARY diagnosed disability** at right***:***        |
| *Please describe any additional disabilities/conditions in the following areas*: |
| [ ]  Physical disabilities  | Please describe       |
| [ ]  Visual disabilities  | Please describe       |
| [ ]  Hearing disabilities  | Please describe       |
| [ ]  Speech disabilities  | Please describe       |
| [ ]  Emotional disabilities  | Please describe       |
| [ ]  Mental disabilities  | Please describe       |
| [ ]  Seizures  | Please describe       |
| [ ]  Allergies  | Please describe       |
| [ ]  Special diet  | Please describe       | Weight        | Height       |
| Medications (continue on additional sheet, if necessary) |
| Medication  | Condition  | Dosage  | Physician  |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Living Arrangements  |
| [ ]  Non-assisted | [ ]  Independent | Address       |
| [ ]  Parents | Contact person       |
| [ ]  Other family member  | Relationship to consumer       |
| [ ]  Assisted | [ ]  Group home | Address       |
| [ ]  Nursing home | Contact person       |
| [ ]  Other       | Relationship to consumer       |

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| Current Criminal Charges/Activity Note: A statement of conviction does not necessarily disqualify a person from receiving services. |
| [ ]  Current legal charges | Please specify        |
| [ ]  On probation | Probation officer name       | phone       |
| [ ]  On parole | Parole officer name       | phone       |
| Insurance Information |  |
| Medicaid | Policy #       | Group #       |
| Medicare | Policy #       | Group #       |
| Other Health Insurance | Policy #       | Group #       |
| Dental Insurance | Policy #       | Group #       |
| Vision Insurance | Policy #       | Group #       |
| ***Health Care Services*** |
| **Primary physician** | Name       | Phone number       |
|  | Address       |  |
|  | Nature of visits       | Frequency       |
| **Dentist**  | Name       | Phone number       |
|  | Address       |
|  | Nature of visits       | Frequency       |
| **Other (specify)** | Name       | Phone       |
|       | Address       |
|  | Nature of visits       | Frequency       |
| **Other (specify)** | Name       | Phone       |
|       | Address       |
|  | Nature of visits       | Frequency       |
| **Other (specify)** | Name       | Phone       |
|       | Address       |
|  | Nature of visits       | Frequency       |

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| Legal Services |  |
| [ ]  Attorney | Name       | Phone       |
|  | Address       |
| [ ]  Executor of will | Name       | Phone       |
|  | Address       |
| [ ]  Trustee of estate | Name       | Phone       |
|  | Address       |
| [ ]  Successor guardian | Name       | Phone       |
|  | Address       |
| Social Services (DDDS, DVR, Conexio Care, Other) |
| [ ]  Case management | Service       |
|  | Contact Name       | Phone       |
| [ ]  DDDS services | Service        |
|  | Contact Name       | Phone       |
| [ ]  Vocational training | Service        |
|  | Contact Name       | Phone       |
| [ ]  Respite care | Service       |
|  | Contact Name       | Phone       |
| [ ]  Transitional services | Service        |
|  | Contact Name       | Phone       |
| [ ]  Cont. treatment | Service        |
|  | Contact Name       | Phone       |
| [ ]  Other (specify)  | Service       |
|       | Contact Name       | Phone       |

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| Part III. History of consumer |
| Medical History (surgeries, serious illnesses, accidents or hospitalizations) |
| Incident  | Dates  | Hospital  | Physician  |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Psychiatric History  |
| [ ]  Psychological evaluation (most recent) | Date       | Psychologist       |
| [ ]  Psychiatric hospitalizations |
| Date admitted  | Date discharged  | Hospital  | Physician  | Courtordered  | Specialtreatment  |
|       |       |       |       | [ ]  Yes [ ]  No |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |
| [ ]  Events preceding a psychiatric/emotional breakdown (please describe) |
|       |
| [ ]  History of drug/alcohol abuse (please specify) |
| Type       Amount       Time frame/duration      Type       Amount       Time frame/duration       |
| [ ]  Inpatient/outpatient treatment for drug/alcohol abuse (please specify) |
| [ ]  In [ ] Out Type       Location       Time frame/duration      [ ]  In [ ]  Out Type       Location       Time frame/duration       |
| [ ]  Suicide attempts  | Please describe       |
| [ ]  Assaultive behavior  | Please describe       |

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| Prior Criminal History  |
| Prior legal charges | [ ]  No [ ]  Yes | Please specify        |
| [ ]  On probation | Probation office name       phone       |
| [ ]  On parole | Parole office name       phone       |
| Living Arrangements History  |
| If consumer has always lived in current arrangement described in Part II, skip to Work History. Otherwise, please complete this section with most recent arrangement first. |
| Type of home [ ]  Family [ ]  Group [ ]  Nursing [ ]  Apartment [ ]  Other       |
| Name of home       | Dates of residence       to       |
| Address       |
| Reasons for leaving  |
| Did this arrangement fit consumer’s needs and strengths? [ ]  Yes [ ] No If no, what would have made the fit better?       |
| Type of home [ ]  Family [ ]  Group [ ]  Nursing [ ]  Apartment [ ]  Other       |
| Name of home       | Dates of residence       to       |
| Address       |
| Reasons for leaving  |
| Did this arrangement fit consumer’s needs and strengths? [ ]  Yes [ ] No If no, what would have made the fit better?       |
| Type of home [ ]  Family [ ]  Group [ ]  Nursing [ ]  Apartment [ ]  Other       |
| Name of home       | Dates of residence       to       |
| Reasons for leaving  |
| Did this arrangement fit consumer’s needs and strengths? [ ]  Yes [ ] No If no, what would have made the fit better?       |

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| Work History |
| Company       | Address       |
| Supervisor       | Sup phone       |
| Type of work       | Hrs/wk       | Start date       | End date        |
| Reason for leaving |
| Company       | Address       |
| Supervisor       | Sup phone       |
| Type of work       | Hrs/wk       | Start date       | End date        |
| Reason for leaving |
| Company       | Address       |
| Supervisor       | Sup phone       |
| Type of work       | Hrs/wk       | Start date       | End date        |
| Reason for leaving |
| Training History (list training programs attended since leaving school) |
| Program name       | Address       |
| Type of program       | Start date       | End date        |
| Reason for leaving       |
| Education History (list most recent school attended) |
| School name       | Address       |
| Type of school       | Start date       | End date        |
| Graduation with [ ]  diploma [ ]  certificate of attendance [ ]  other       |
| Volunteer History |
| Organization       | Address       |
| Supervisor       | Supervisor phone       |
| Type of volunteer work       | Hours per week       | Start date       |

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| Part IV. Considerations for Planning |
| Current Abilities |
| Self-care skills |  |  |  |
| Use toilet | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Care for menstrual needs | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Bathe/shower | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Wash hair | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Shave | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Brush teeth | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Use deodorant | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Select clothes | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Get dressed | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Comb hair | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Feed self | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Self-medicate | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Mobility skills |  |  |  |
| Walk/move  | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Cross streets | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Use public transportation | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Drive | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Housekeeping skills |  |  |  |
| Cook simple dinner | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Prepare menu and grocery list | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Purchase groceries | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Clean bedroom | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Clean living spaces (kitchen, bath, etc.) | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Do laundry | [ ]  Independently | [ ]  With assistance | [ ]  Unable |
| Shop for clothes | [ ]  Independently | [ ]  With assistance | [ ]  Unable |

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| Cognitive skills |
| Print | [ ]  No [ ]  Yes | Extent       |
| Write | [ ]  No [ ]  Yes | Extent       |
| Read | [ ]  No [ ]  Yes | Extent       |
| Tell time | [ ]  No [ ]  Yes | Extent       |
| Bank | [ ]  No [ ]  Yes | Extent       |
| Pay bills | [ ]  No [ ]  Yes | Extent       |
| Use computer | [ ]  No [ ]  Yes | Extent       |
| Method of Communication |
| [ ]  Verbal | [ ]  Gestures | [ ]  Sign language | [ ]  Other       |
| Expresses needs | [ ]  Yes | [ ]  No |
| Initiates conversation | [ ]  Yes | [ ]  No |
| Uses telephone | [ ]  Yes | [ ]  No |
| Safety Awareness |
| Is the consumer aware of the following household dangers? |
| Electrical outlets | [ ]  Yes [ ]  No | Comment       |
| Kitchen stove and oven | [ ]  Yes [ ]  No | Comment       |
| Cleaning supplies | [ ]  Yes [ ]  No | Comment       |
| Fireplace | [ ]  Yes [ ]  No | Comment       |
| Is the consumer aware of the following community dangers? |
| Traffic | [ ]  Yes [ ]  No | Comment       |
| Overly friendly strangers | [ ]  Yes [ ]  No | Comment       |
| Wandering off | [ ]  Yes [ ]  No | Comment       |
| Knows and applies simple first aid | [ ]  Yes [ ]  No | Comment       |
| Responds to household emergency | [ ]  Yes [ ]  No | Comment       |
| Knows and can repeat  | [ ]  name | [ ]  address | [ ]  phone  |

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| Part v. GOALS |
| Consumer’s **current** plans/goals:      |
| Consumer’s **future** plans/goals:      |
| Representative’s **current** plans/goals for the consumer *(including residential placement)*:      |
| Representative’s **future** plans/goals for the consumer *(including residential placement)*:      |

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| Part vI. Additional information and Documents |
| Please use this space to add any additional information that may be helpful to have on file regarding the consumer. Attach important documents, such as pre-need funeral plans, guardianship or other court documents, behavioral reports, etc. |