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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 |
|  | |  |  |  |
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| 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 | | |
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| Psychiatric History | | | | | | | | | | | | |
| Psychological evaluation (most recent) | | | | | Date | | | Psychologist | | | | |
| Psychiatric hospitalizations | | | | | | | | | | | | |
| Date  admitted | Date  discharged | | | Hospital | | Physician | | | Court ordered | | Special treatment | |
|  |  | | |  | |  | | | 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. |