Name:	Main Contact:	Relationship:	Date of Birth	Primary Phone:
[redacted]	[redacted]	mom/guardian	[redacted]	[redacted]

Street Address:	City:	State:	Zip Code:	Email:
[redacted]	Phoenix	AZ	85041	[redacted]

Primary Diagnoses:	Secondary Diagnoses:
Autism	Down Syndrome
Name of school (if still a student):	How did you hear about us?
	School / Metro tech

PROGRAMS AND SERVICES

Office Use Only

Which Campus or Community Based Setting Interests You:

☑ Phoenix Campus ☐ Casa Grande Campus ☐ Maricopa Campus ☐ Avondale Campus

Location/Site:

Funding Source:

☑ Division of Developmental Disabilities
☐ Private Pay (PP)
☐ Other:

What Programs/Services Interest You:

☑ Adult Day Training/Habilitation/Activities
☑ Work Center Vocational Training
☐ Community-Based Enclave
☐ Individual Supported Employment
☐ Youth/School-Age/Transitions Programs
☐ Weekend Program (1-2 hours, Seasonal)
☑ Transportation

Start Date:

Service Codes:

☐ DTA
☐ CBE
☐ GSE
☐ ESA ☐ ISE
☐ DTT ☐ DTS
☐ RSP
☐ TRA ☐ TRE

DDD Support Coordinator/Service Contact:

Name: [redacted]
Phone:
Email: [redacted]

Transportation AM:	Transportation PM:
Yes	Yes
Phone:	Phone:

EMERGENCY CONTACTS

Emergency Contact, Primary:	Relationship:	Home Phone:	Work/Cell Phone:
[redacted]	mom/guardian	[redacted]	
Emergency Contact, Secondary:	**Relationship:**	**Home Phone:**	**Work/Cell Phone:**
[redacted]	Stepdad	[redacted]	
Residential Manager (If Applicable):		**Residence Phone:**	**Mgr. Work/Cell Phone:**

GUARDIAN INFORMATION

☑ Legal Guardian ☐ Conservator ☐ Self-Guardian (skip this section)

Name:	Relationship:
[redacted]	Mom
Street Address:	
[redacted]	

City:	State:	Zip Code:
Phoenix	AZ	85041
Email:	**Primary Phone:**	
[redacted]	[redacted]	

FAMILY INFORMATION *Parent(s) or Primary Family Representative*

☑ Same as Guardian (skip this section) ☐ Co-Guardian/Parent at Different Address

Name(s):	Relationship:
Street Address:	

City:	State:	Zip Code:
Email:		**Primary Phone:**

HEALTH & MEDICAL

Additional Relevant Diagnosis/ Medical Needs: Heart Condition, AAI

Insurance Company: [redacted]

Policy Number: A[redacted]

Insurance Company:

Policy Number:

Height: [redacted]

Weight: [redacted]

Seizures: ☐ Yes ☒ No

[redacted]es, Please Complete Attached Seizure Information Page!

Chronic or Reoccurring Medical Conditions: Cough

Special Health-Related Instructions:

MOBILITY

☑ Fully Ambulatory ☐ Independent with Wheelchair ☐ Needs Full Assistance

Walks with Assistance with: ☐ Person ☐ Equipment

Please Describe: he is ambulatory but walks very, very slow.

DIET & NUTRITION

Special Dietary Requirements: none

Allergies (Foods, Medications): none

Eating & Drinking Practices:

☑ Independent (All Foods) ☐ Soft Foods Only

☐ With Adaptive Equipment

Please Describe:

☑ Requires Assistance and/or Supervision

Please Describe: Cutting big foods

PERSONAL CARE / MOTOR COORDINATION

Fine motor impairments: *Include options for assistance (hand over hand, modified utensils, etc)*

Flacid fingers but can mostly do things w/ no assistance

Toileting & Menstrual Care:

☑ Independent Sometimes doesn't wipe well but independent.

☐ Occasional or Regular Reminders

☐ Requires Assistance

Please Describe:

PRESCRIPTION MEDICATION *(If Medications Exceed Space Provided, Please Attach Separate List)*

Medications	Time(s) Administered	Dosage
none		

Demographics

All demographic data submitted statistically. Individual confidentiality shall be maintained for our members.

GENERAL

Member Identification Code *(Office Use Only)*:	Program Start Date:	Date of Birth

Street Address:	City:	State:	Zip Code:	Phone Number:
[redacted]	Phoenix	AZ	[redacted]	

Race:

- ☐ Caucasian/White
- ☐ American Indian/Alaskan Native
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other Multi-Racial

Ethnicity:

- ☑ Hispanic
- ☐ Non-Hispanic

DISABILITY

Primary Diagnoses:	Secondary Diagnoses:
Autism / Down Syndrome	

Disability – *Please Check All That Apply*:

- ☐ Physical Disability (PD)
- ☑ Developmental Disability (DD)
- ☐ No Disability
- ☐ PD Re: Work
- ☐ DD Re: Work
- ☐ Other
- ☐ PD Re: Transportation
- ☐ DD Re: Transportation

RESOURCES

PLEASE CHECK ALL BENEFITS PARTICIPANT RECEIVES:

- ☐ Social Security
- ☑ SSI
- ☐ SSDI
- ☑ AHCCS ALTCS
- ☐ Other:
- ☐ TANF
- ☑ Food Stamps
- ☐ General Assistance
- ☐ Veteran's Compensation

HOUSEHOLD

TYPE OF RESIDENTIAL SETTING:

- ☑ Family (Of Origin) Home
- ☐ Group Supported Living (Group Home)
- ☐ Adult Developmental Home (ADH)
- ☐ Individually Designed Living Arrangement (IDLA)

TOTAL NUMBER OF INDIVIDUALS LIVING IN HOUSEHOLD INCLUDING

PARTICIPANT: 4

Communication & Social Life

Does the applicant clearly communicate their wants and needs?	What form of communication is the easiest way for the applicant to express themselves to others?
___ Yes ✓ No Semi verbal	✓ Speech device ✓ Communication ___ Sign language ___ Other (describe in section below) ___ Gesturing
Which most accurately describes the applicant's speech?	**What form of communication makes it easiest for the applicant to understand others?**
___ Easily understood by everyone ✓ Understood by those familiar with them ___ Limited verbal ability ___ Non-verbal	✓ Speech device ✓ Communication ___ Sign language ___ Other (describe in section below) ✓ Gesturing

Are there any considerations that we should make when communicating with the applicant?

He will mix spanish w/ his english sometimes but speaks both

Does the applicant currently receive any therapies? If so, please briefly describe their current goals so we can help provide consistent standards for the applicant's communication while they're in program.

PT, Speech, OT, music

Seizure information

Does the applicant have any history of seizures? ☐Yes ☒No ***If yes, please complete this page***
Been 10 years doesn't take meds

Has the applicant had any seizure activity in the past 5 years? ☐Yes ☒No

When (month/year) was the last seizure?

Are the seizures currently being controlled with medication? ☐Completely controlled ☐Partially controlled ☐Not controlled

How frequently does the applicant have seizures (times per day, week, month, or year)?

How long can a seizure last before medical intervention becomes necessary? __ _____

Describe any antecedents to a seizure:

Is there any noticeable change in behavior after a seizure (e.g. groggy, confused, irritable, etc)?

How does a seizure typically present itself? Please describe the physical characteristics, and the typical duration:

Describe medical interventions that are appropriate and available in an emergency (nerve stimulator, medication, length of seizure before calling paramedics, etc.).

Please discuss any other information relating to seizures that is important for the individual's safety?

Behavior and Personality

Does the applicant exhibit age appropriate social skills? ___Yes ___/__No

If no, please describe the behavior that is not age appropriate:

[redacted] is very shy and doesn't interact w/ others unless prompted or initiated by others first

Please indicate which of the following have ever been concerns for the applicant.

Check all that apply:		Describe behavior:	Frequency (times per day, week, month, or year)
Hurtful to self (suicidal)			
Hurtful to others	>	if very overwhelmed he might lash out	3x year.
Destructive to property	>		
Repetitive behavior	/	repeats words a lot	
Withdrawn or inattentive behavior	/		
Running away			
Verbal aggression			
Physical aggression			
Pica			
Fall frequently			
Lacks stranger danger skills	/		
Risk of exploitation	/		
Other:			

If yes to any of the above, please describe the context of the behavior, including when the last instance was, possible causes of the behavior, and effective techniques to resolve the situation. Feel free to include additional pieces of paper to give the most detailed information possible.

When overwhelmed by extreme loud screams or someone taking something forcefully from him he might throw something. If scared he will throw a punch. It is very, very rare

If any of these behaviors have caused a concern for the safety of the applicant or other people, is anything currently being done to manage the behavior? This might include a formally implemented Behavior Treatment Plan, an approach to handling stress, therapy, or avoiding particular triggers for the behavior.

Not recurrent enough. He immediately says sorry and calms down w/ talking

Does the applicant have any behaviors that come before the harmful behavior? What warning signs are exhibited by the applicant that would help us deescalate the situation before it becomes unsafe?

No- unexpected

Check the option that you feel is most accurate:

___ The applicant enjoys interacting with others

___ The applicant prefers to spend time by themselves

/ The applicant is withdrawn at first, but is more outgoing once they are comfortable in a situation

What sort of environment does the applicant prefer most of the time?

/ Calm, low stimulus and relaxing

___ Active, stimulating and engaging

Does the applicant have any sensitivity to light, sound, touch or other sensory perceptions that we might consider in order to create a positive and comfortable environment for them?

extreme sounds like screaming or crying bother him.

What are some activities that the applicant enjoys, or that they might enjoy if given the opportunity? This might include participation in arts programs (like painting, photography, or theatre), regular physical exercise, volunteering in the community, or something that they've expressed interest in the past. Please be as specific as possible.

volunteering, ~~washing dryer~~ laundry, cafeteria help, water activities, painting, simple snack making, vacuuming

Learning and Personal Growth

Can the applicant identify the current day of the week? ___Yes ___No

Can the applicant identify the current day of the year? ___Yes ___No

Can the applicant tell time on a digital clock? ___Yes ___No

Can the applicant tell time on an analog clock? ___Yes ___No

What is the highest number the applicant can count to without assistance? 10

What is the applicant's current math comprehension?

___ Completes basic addition and subtraction problems

___ Completes basic multiplication and division problems none

___ Math skills are equivalent to a freshman in high school

___Math skills are equivalent to a high school graduate

___ Math skills are at a post high school level

Please check all of the following that describes the applicant's money management skills:

___ Can count bills understands things cost money but doesn't know how to count/handle it.

___ Can count change

___ Understands how to make a purchase in a store using money or credit cards (may need assistance in counting the money)

___ Can plan a budget for at least one shopping trip

What is the applicant's current reading comprehension?

___ No ability to read

___ Reads sight words and identifies symbols (stop signs, restroom signs, etc.)

___ Simple reading (around the level of a 3rd grader)

___ Average reading (at least middle school or junior high level)

___ Advanced reading (post high school level)

Which academic and life skills would be most beneficial for the applicant to spend time improving? Check all that apply:

___ Reading

___ Math

___ Writing

- [x] Money management
- [x] Communicating with others more clearly
- [ ] Communicating with others in a more positive way
- [x] Cooking
- [x] Cleaning (house work)
- [x] Safety skills

Other: _____

What teaching techniques tend to be the most effective for the applicant when learning a new skill? Check all that apply:

- [ ] Hand over hand instruction
- [x] Step by step spoken instructions
- [ ] Step by step written instructions
- [x] Instructor modeling
- [x] Peer modeling
- [ ] Self video modeling

How many instructional steps can the applicant follow at a time? 2

Please describe any other teaching techniques that might be effective:

pictures to show steps, velcro cross to signify what steps he already finish; Encouragement, praise.

What would the applicant most like to get out of their time at The Opportunity Tree? Some of these goals may be achieved within a few weeks of being in the program, while others may take several years. Consider what some of those short term goals might be, as well as some long term goals (in the next 5-10 years).

Check all that apply:

- [x] Have something to do during the day
- [x] Enjoy being in a fun, active, positive environment
- [x] Make new friends
- [x] Increase self-esteem
- [x] Learn new daily living skills
- [ ] Learn new academic skills
- [x] Learn new work skills
- [ ] Earn a paycheck
- [x] Work in one of our community enclaves
- [ ] Develop the skills to find a job independently
- [ ] Develop the skills to live independently

Medical History

Individual: _____ **Updated:** _____

Type of Disability: Check (✓) as applicable

☐ Autism ☐ Epilepsy ☐ Cerebral Palsy ☐ Cognitive Impairment ☐ Other (explain): mild intellectual disability

Developmental History: Birth date: _____

Family Medical History: If a member of the family has had any of the following, check (✓) the applicable box(es).

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Mental Illness ☐ Other (explain):

If the individual has or has had any of the following, please check (✓) as applicable:

- ☐ Anemia
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Chronic Bronchitis
- ☐ Chronic Ear Infection
- ☐ Chronic Nose Bleeds
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Gall Bladder Problems
- ☐ Gastritis
- ☐ Head Trauma/Injury
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Fever
- ☐ Immune Suppressed Disorder
- ☐ Liver Disorder
- ☐ Measles
- ☐ Meningitis
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Substance Abuse/Addiction
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Valley Fever
- ☐ Venereal Disease

Immunizations: Check (✓) if current and provide dates

- ☐ Tetanus:
- ☐ Hepatitis B Screening
- ☐ DPT:
- ☐ Measles:
- ☐ PPD (TB Screening):
- ☐ Hepatitis B Vaccination:
- ☐ Polio:
- ☐ Other :

Allergies: ☐ Yes ☐ No If "Yes", specify:

Dental History: ☐ Gum Disease ☐ Orthodontic Appliances (specify):

Current Medications:

Date of Last Physical Examination:

Surgeries, Hospitalizations, Treatments, and Significant Accident Injuries: (Attachment)

Date	Diagnosis	Hospital	Physician/Therapist

Resident's Name:	Sex: Male	Date of Birth:

HEALTH / MEDICAL

ALLERGIES (Specify):
Signs and Symptoms:
Steps to be taken if signs appear:

MEDICAL CONDITIONS (Specify):
Signs and Symptoms:
Steps to be taken if signs appear:

NUTRITIONAL NEEDS
Food Preparation: Regular __ Bite-size ___ Puree ____ Other (Specify) _____
Special Diet: Yes ____ NO ____
Specify:
Nutritional Supplements: Yes ____ NO ____
Specify:
Choke or gag reflex: Yes ____ NO ____
Assistance required during mealtimes (i.e. adapted utensils, positioning, etc.):
YES ____ NO ____
List:

SPECIAL FLUID INTAKE NEEDS:
Can the resident obtain / request fluids? Yes ____ NO ____
If no, specify system to ensure adequate fluids are provided:

Specify medical / nutritional fluid recommendations (if applicable):
No soda please

ADAPTIVE EQUIPMENT, PROTECTIVE DEVICES, AND FACILITY ADAPTATIONS
Adaptive Equipment (i.e. Glasses, hearing aids, wheelchairs, communication devices, etc.): Yes ___ NO ___
List:
Special Instructions:
Protective Devices: Yes ___ NO
List:
Facility Adaptations (i.e. Ramps, Plexiglas windows, grab bars, etc.): Yes ___ NO ___
List:

RESIDENT NAME:

SPECIAL INSTRUCTIONS FOR LIFTING, CARRYING, AND POSITIONING: YES ___ NO ___
If YES, specify:
Equipment:
Time Schedules:

HEALTH CARE RELATED ISSUES PER BEHAVIOR MANAGEMENT/ISP TEAM
BTP: ___ NO ___ IF YES, TARGET BEHAVIORS: **Other interfering behaviors not requiring BTP:**

OTHER ADDITIONAL HEALTH CARE NEEDS/ROUTINES (i.e. tooth brushing, flossing, nail care, etc.):

GROOMING / PERSONAL CARE

SPECIAL INSTRUCTIONS FOR BATHING: Yes ___ NO ___
Methods:
Products:
Supervision:
Gender Preference: Male ___ Female ___ No Preference ___

COMMUNICATION

Can resident express wants and needs: Yes ___ NO ___
Type of Communication (i.e. verbal, sign, gestures, augmentative devices, etc.):
If NO, steps to take to meet resident's needs:

SPECIAL MEDICAL MONITORING

SPECIAL LAB WORK REQUIRED (i.e. Lithium levels, Dilantin levels, thyroid, etc.): YES ___ NO ___
Specify:
Frequency:

SEIZURE MEDICATION: Yes ___ NO ___
Are seizures documented? YES ___ NO ___ If YES, Specify:

BLOOD PRESSURE MEDICATION: Yes ___ NO
Parameters established by physician: Yes ___ NO ___
What monitoring techniques are used (i.e. frequency, ranges, etc.):
If blood pressure is out of established ranges, what procedures should be implemented:

DIABETIC: Yes ___ NO ___
Frequency of blood sugar levels:
Parameters established by physician:

Please have a physician complete the included physical form and return with the following items-

- Psychological exam-preferred within 3 years.
- Current copy of the applicant's ISP.
- Current copy of Behavior Treatment Plan (If applicable.)
- Immunization records.
- Hepatitis B/TB screenings or proof of shots.

Thank you for taking the time to thoroughly complete this application, we look forward to the intake meeting!