

## I. Demographics

Individual Name	Date of Report 08/14/2009
Current Address:	
Date of Birth:	Social Security
Telephone #	Medicaid
Private Insurance Carrier:	Medicare
Service & Support Administrator:	
Individual Service Plan Span Date:	
Residential Provider: Independent Choices	
Day Service Provider:	
Current Employer/School Name:	
Level of Mental Retardation:	

### Waiting List:

Copies of the following are required for new enrollees	State Identification Card- Is your state identification current <input type="checkbox"/> Yes <input type="checkbox"/> No Does it expire this year <input type="checkbox"/> Yes <input type="checkbox"/> No
	Medicaid and/or Medicare Card
	Social Security Card
	Birth Certificate
	Guardianship Papers

## II. Choices & Options

Self:	
Court Appointed Type:	
Limited to:	
Do you have a Durable Power of Attorney for Health Care?	
Do you have a Living Will?	
Do you have a job?	
Do you like your job?	
Do you need help finding a job?	
Do you have a daily representative? Who?	
Do you have family that provide or will provide support to you? Who and when?	
Do you have privacy where you live?	
Do you like where you live? If not, where would you like to live?	

## Functional Assessment

Do you like who you live with? If not, who would you like to live with?		
Do you like your daily routine? If not, what would you like to change?		
Do you decide when you go to bed and when you wake up?		
Do you decide what you would like to buy? When you buy something, who helps you?		
Are any of your possessions kept from you? Why?		
Who helps you keep a list of personal possessions? (Needed when two or more persons live in a setting)		
Do you need help making decisions? Who would you like to help you?		
Who has keys to your home? (Does not include 24-hour homes.) Can you lock/unlock your home?		
Can you express needs and wants in a manner that is understandable to people who do not know you, using spoken, written, signed, electronic or mechanical means? Can (you/others) understand such communications.		
What methods of expressive communication do you use?		
What method of receptive language do you prefer?		

### III. Personal Income

Do you have a payee?		
Do you need a payee?		

#### A. Source of Income

Supplemental Security Disability Income?	Amount	\$0.00	Per Month	
SSA	Amount	\$0.00	Per Month	
SSI	Amount	\$0.00	Per Month	
Railroad / VA	Amount	\$0.00	Per Month	
HUD	Amount	\$0.00	Per Month	
Net Wages	Amount	\$0.00	Per Month	
Food Stamps	Amount	\$0.00	Per Month	
Savings Account	Amount	\$0.00	Bank	
Checking Account	Amount	\$0.00	Bank	
Lock Box in Home (Cash on Hand)	Amount	\$0.00		
Other	Amount	\$0.00		
Trusts	Amount		Bank	
Who helps you maintain your benefits?				
<i>Note: All accounts should be "Payable upon death" accounts.</i>				

#### B. Monthly Payment Obligations

## Functional Assessment

Can you access insurance and / or public benefits?			
Burial Plan? Cost monthly: \$0.00		0	
Company Name: Address: City, State: ,		Cemetery: Address: City, State: ,	
Insurance Type: Company Name: Address: ,			
<b>Monthly costs:</b>			
Transportation cost: \$0.00	Food/Supplies: \$0.00	Rent: \$0.00	Trash: \$0.00
Gas: \$0.00	Medical Bills: \$0.00	Electric: \$0.00	Telephone: \$0.00
Cable: \$0.00	Medical Insurance: \$0.00	Laundry: \$0.00	Water/Sewer: \$0.00
Personal: \$0.00	Recreational: \$0.00	Home Maintenance: \$0.00	Business Costs: \$0.00
Spend Down: \$0.00	Room & board: \$0.00		
Other:  \$0.00 \$0.00 \$0.00 \$0.00		Who writes and signs your checks?	
		Who does your income taxes?	
		Who reconciles your check book?	
Can you independently manage your money?			
You can independently carry how much money?		\$ 0.00	
Does someone help you budget? Do you have someone who pays bills? Who?			
What are you saving money for?			
Have you had insufficient bank and/or utility shut-off notices over the last year?			

### IV. Housing

Describe the individual's current living arrangements (i.e. group home, with family, apartment, Northland Home, own your own home).			
Landlord's name: Address: Phone:			
Do you have basic furnishings?			
Are there any home modifications or equipment that would help you be more independent or improve your life?			

## Functional Assessment

Do you have any condition that places you at significant risk of institutionalization?		
How do you access transportation?		
Can you -	Do Laundry?	
If you don't who does it?	Straighten your home?	
	Empty trash?	
	Clean the bathroom?	
	Make your bed?	
	Vacuum and mop?	
	Heavy chores?	
	Make a grocery list?	
	Plan and prepare a healthy meal?	
	Use the stove?	
	Use the microwave?	
	Use the dishwasher?	
	Use the coffemaker, toaster or small appliances?	
	Use the telephone?	
	Shopping/Grocery?	
	Vending Machine?	
	Do yard work?	
Who decides what temperature your bedroom or home is?		
Who decides how your bedroom and home is decorated?		
Who packs your lunch?		

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## V. Community Membership

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Functional Assessment

Do you talk to friends and family on the phone or internet? Who? How often?		
To what organizations, clubs or church do you belong?		
What vacations do you want to take? How would you pay for it?		
Who do you like to hang out with?		
Is there something that you want to change in your life? Would you feel comfortable saying so?		
In what activities do you like to participate?	0	Day Programming
In what would you like to participate?	0	Sports
Are you a registered voter? Do you need someone to take you to vote?		
Do you need someone to help you with your mail?		

**VI. Personal Satisfaction**

Are you happy with your services, supports, and activities in which you participate?		
Are you happy with the interaction with the persons who provide these services and supports?		
Do you feel free to express your desire to change the services, supports, and activities on your ISP?		
Do you feel that the county board and service providers listen to and respond to your choices for services, supports, and activities?		
Have you had 3 or more complaints within the past year? Have you filed due process during the last year?		
Do you know who to go to if you want to complain? Do you know what to do to file a complaint?		

**VII. Health**

<b>Pharmacy of Choice</b>		
<b>Address</b>		
Felbinger, Jennifer S. O.D. 00:00:00	Office Phone: 4197342106	Last Appointment: 5/28/2009
Lake Erie Family Eye Center Port Clinton, OH 43452	Emergency Phone: Cell Phone: Fax:	Next Appointment:

**Health Questions**

## Functional Assessment

What are your medical/psychiatric/psychological diagnoses?		
Do you take psychotropic medications?		
Do you take anti-depressants?		
Do you take anti-anxiety medications?		
Do these require psychiatric diagnosis?		
<b>Self-Administration Assessment</b>		
Is the individual able to identify medication(s)		
Able to indicate why he/she takes medication(s) [For example: for my seizures, my asthma, I get upset very easily]		
Correctly indicates doses of medication(s)		
Indicate health changes or when not feeling well. [For example: taking a new pill and now my mouth is dry, my stomach hurts, etc]		
Able to indicate what to do when meds are low. [For example: ask staff, go to drug store.]		
Able to indicate what time to take medication(s) either by clock time or related to a specific routine (after breakfast, before bedtime)		
Is physically able to get medication(s) from storage, get medication (s) out of container and physically take/apply medications(s) If no, indicate what physical assist you may need.		
Do you have a seizure disorder?		
Do you experience seizures that involve loss on consciousness?		
Do you have a medical condition that leaves you dependent on life support medical technology? (Ventilator, dialysis, feeding tube for primary nutrition, etc.)		
What daily assistance do you need for medical procedures/equipment?		
Have you been in the hospital/nursing facility in the past year?		
Do you have "Do not resuscitate" order?		
Do you have a visual impairment?		
Do you have a hearing impairment?		
Do you have a condition affecting multiple body systems for which a combination of specialized medical, psychological, educational or habilitation services are needed? (Prader-Willi, Spinal Muscular Atropy, Cerebral Palsy, etc)		
<b>On-Site/On-Call</b>		
Do medical needs require monitoring through the night?		
Do behavior needs require monitoring through the night?		
Do special dietary needs/restrictions require monitoring during the night?		
Do mobility limitations require intervention through the night?		
How many hours do you sleep?		
How many times do you wake up?		
What kind of intervention do you need when you wake up?		

Functional Assessment

Is there any intervention needed during sleep hours to ensure health & safety?		
Has your doctor recommended a special diet?		
If yes, is a nutritionist involved?		
What adaptive equipment do you use?		
What is birth control?		
What is safe sex?		
Do you need birth control?		
Are you sexually active?		
What do you need help with?	Bath/Shower	
	Wash hair	
	Brush teeth/dentures	
	Shave	
	Apply deodorant	
	Nail care	
	Menstrual care	
	Toileting	
	Getting dressed	
	Choosing clothes	
	Hair styling or cutting	
	Eye wear or eye care	
	Hearing aid care	
	Eating/feeding	
	Mobility	
Bed mobility		
Transfer		
Ambulation		
Locomotion		

**VIII. Safety**

Do you have in your home: First aid kit? Carbon monoxide detector? Smoke detector? How often are they checked? Who checks them? Are they working?		
Do you know how to independently travel around town by walking or riding your bike safely?		
Do you have pedestrian safety skills?		
Do you have bike safety skills?		
How do you get out of your house during a fire?		
Do you do safety drills? Fire, tornado, other emergency? How often?		
Do you know how to get emergency help?		

Functional Assessment

Do you know how to dial 911?		
What do you do during different emergencies like: Stranger at your door Stranger on the phone You have a broken bone		
Can you explain what to do in the following emergency situations? Fire Gas leak Weather emergency Major emergency in the home that could cause damage If smoke or CO alarm sounds If your power/lights are off If you have no heat		
What do you do when someone touches you and you don't like it?		
Can you spend time alone at home or in town without staff? If so, how long?		
<b>Unsupervised time in the community</b> Are there conditions (medical, psychiatric, behavioral) which would be detrimental to own or others health and safety if left unsupervised in the community? Can you give personal information (name, address, phone)? Do you carry identification? Do you use adaptive equipment for safety? (if yes, explain) Can you do the following: Cross streets with signals? Cross streets without signals? Display safety behavior with strangers? Display safe behavior with animals? Identify community members to access in an emergency? Following a familiar route or travel within a familiar neighborhood without confusion? Use appropriate social skills in the community?		
Do you know how to store and use poisons and cleaning supplies in your home? Do you need help to safely store them out of reach?		
Who changes your furnace filters? How often? Who empties your lint trap? How often?		
Who do you contact for home maintenance problems such as water leak, toilet running?		
Do you use a seatbelt when riding in a car or van?	0	
Do you do anything that gets you into trouble?	0	