



**Attach  
Photo**

## **Friendship Community**

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### **Provider of Choice Information**

**This form is strictly an informational piece for the purposes of Friendship Community. Completion and submission of this form does not imply or guarantee that services or placement will be provided by Friendship Community.**

**Your county Office of Mental Health/Mental Retardation is the primary reference point upon which services are offered. Friendship Community requests the following information on individuals who have indicated that Friendship Community would be the service provider of choice. Friendship Community strongly recommends that this preference be shared with the appropriate county Support Services Coordinator.**

#### **A. General Information**

1. Date Completed: \_\_\_\_\_ Date of Above Photo: \_\_\_\_\_  
(Use photo less than 5 years old)
2. Name (Last, First, Middle) \_\_\_\_\_
3. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
4. Home Phone \_\_\_\_\_
5. Date of Birth \_\_\_\_\_
6. Male \_\_\_\_\_ Female \_\_\_\_\_ (check one)  
Married \_\_\_\_\_ Single \_\_\_\_\_ (check one)
7. Social Security Number \_\_\_\_\_

**B. Family Information**

1. Father's Name (Last, First, Middle) \_\_\_\_\_
2. Father's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Home Phone \_\_\_\_\_
4. Date of Birth \_\_\_\_\_
5. Mother's Name (Last, First, Middle) \_\_\_\_\_
6. Mother's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
7. Home Phone \_\_\_\_\_
8. Date of Birth \_\_\_\_\_
9. Name of Next of Kin \_\_\_\_\_
10. Address of Next of Kin \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

**C. Guardianship Information**

1. Name of Legal Guardian (if have one) \_\_\_\_\_
2. Address of Guardian \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

**D. Referral Information**

1. Name of Referring Agency \_\_\_\_\_
2. Address of Referring Agency \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_
3. Reason for Referral \_\_\_\_\_
4. Name of Supports Coordinator \_\_\_\_\_
5. Are you on your county's PUNS (prioritization of urgency of need for service) list? \_\_\_\_\_  
If so, what is your status? \_\_\_\_\_

**E. Supports Information**

1. Please list any additional names, addresses, and phone numbers of people who currently provide support.

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2. Please list any agencies currently providing services and a contact person / phone number.

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**F. Diagnosis Information**

1. Is the primary diagnosis mental retardation? \_\_\_\_\_

2. If so, what is that diagnosis (mild, moderate, severe, profound)? \_\_\_\_\_

3. Is there a mental health diagnosis? (If yes, please list diagnosis)

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4. What, if any, medical diagnoses are present? \_\_\_\_\_

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5. Please list current medications, if any. \_\_\_\_\_

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**G. Financial Information**

1. Average monthly income? \_\_\_\_\_

2. Sources of income? (Please list amounts below)

Supplemental Security Income (SSI) \_\_\_\_\_

Social Security \_\_\_\_\_

Wages from Employment \_\_\_\_\_

Other \_\_\_\_\_

**H. Medical Insurance Information**

1. Does the individual have medical insurance? \_\_\_\_\_
  
2. What is the policy name? \_\_\_\_\_  
Policy number \_\_\_\_\_

**I. Education Information**

1. Did he/she graduate from High School? \_\_\_\_\_
  2. How old was he/she when they completed school? \_\_\_\_\_
  3. What school/s did he/she attend? \_\_\_\_\_
  4. What classes were attended? (IU, Special Ed, Vo-tech, etc.) \_\_\_\_\_  
\_\_\_\_\_
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**J. Behavior Assessment Information (please check the description which fits best).**

	Generally pleasant and cooperative
	Excessive talking, demands for attention, moodiness, over sensitivity, depressive, withdrawn, mental health disorder
	Uncooperative, resistive, quarrelsome
	Hyperactive, loud, temper tantrums, mental health disorder which interferes with daily living, disruptive, destructive

**K. Ambulation Assessment Information (please check the description which fits best).**

	No problems
	Slowness, unbalance, physical assistance with stairs or uneven surfaces
	Uses walker, physical assistance with getting in/out of tub and vehicle
	Wheelchair, bedfast, crawls

**L. Self-Care Assessment Information (please check the description which fits best).**

	Can perform tasks independently - may need reminders
	Requires verbal step-by-step assistance
	Hands on assistance
	Total care

**M. Medical Assessment Information (please check the description which fits best).**

	Self-medicates
	Requires assistance with taking medication
	2 or more medical problems which require assistance
	Frequent seizures, eating disorder, frequent doctor visits, g-tube

**N. Additional Medical Information**

1. Please list any allergies. \_\_\_\_\_

\_\_\_\_\_

2. Is a special diet followed? (Specify and Describe) \_\_\_\_\_

\_\_\_\_\_

3. Are any of the following used? (Please check all items used)

\_\_\_\_\_Hearing Aid

\_\_\_\_\_Wheelchair

\_\_\_\_\_Crutches

\_\_\_\_\_Cane or Walker

\_\_\_\_\_Artificial Limb or brace

\_\_\_\_\_Dentures

\_\_\_\_\_Glasses or Contacts

\_\_\_\_\_Special Bed

\_\_\_\_\_Therapy (speech, physical, vision, other) \_\_\_\_\_

\_\_\_\_\_Other \_\_\_\_\_

**Additional Information**

1. Does he/she know how to evacuate in the event of a fire and how much assistance, if any is needed in evacuations? \_\_\_\_\_

\_\_\_\_\_

2. Does he/she know what to do in an emergency and how to access 911? \_\_\_\_\_

3. Does he/she recognize and act accordingly with strangers? \_\_\_\_\_

4. What does he/she enjoy doing (activities, social events, hobbies, etc.)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Please list strengths and skills. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. What are some of he/she's dreams for the future (employment, living arrangement, etc.)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

We welcome your response to the following questions:

How did you become aware of Friendship Community?

What is your reason for choosing Friendship Community as a provider of choice?

Signature: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_

Date Completed: \_\_\_\_\_