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 named) _____
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.

_____

_____

_____

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

_____

_____

_____

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)

_____

4. What, if any, medical diagnoses are present? _____

_____

_____

5. Please list current medications, if any. _____

_____

_____

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.) _____

_____

_____

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:_____