ASSISTED INDEPENDENCE, LLC.

www.assistedindependence.care P.O. Box 1683, Columbus, IN 47202 812-374-9450

INDIVIDUAL INTAKE FORM

Instructions: This form is NOT to be completed by an individual supported and/or their family. Rather, the Assisted Independence employee is to use this form as an outline during an Intake Meeting or "Meet-and-Greet". The form does NOT have to be followed precisely. The form is intended to be a conversation starter for the employee to gain applicable knowledge about the individual supported. If an individual or family does not have the information to complete any of the fields below, refer to documents such as the Person-Centered Individualized Support Plan (PCISP).

Date: _____

Demographic Information

Name: _____ DOB: _____ Sex: _____

Parent/Guardian Name(s): _____ Emancipated: YES or NO

Primary Diagnosis: _____

Secondary Diagnosis: _____

Current School and Grade (if applicable): _____

Current Place of Employment and Position (if applicable): _____

Living Arrangements (circle one): Family Home / Independent Home / Supporting Living Site / Other

Emergency Contact: _____ Relationship: _____

Phone Number: _____ Email: _____

Contact Information

Phone Number: _____ Email: _____

Secondary Number: _____ Email: _____

Primary Address: _____

Secondary Address (if applicable): _____

Personal Information

Interests (Hobbies, Activities, Medias, Locations, Etc.): _____

_____

List two goals that the individual is currently working on: _____

_____

My personality is: _____

_____

Things I want to improve on are: _____

_____

My favorite thing about myself is: _____

_____

Do you have any personal views or values you would like us to be mindful of? _____

_____

Visits with Friends and Family

Who are the important people in your life [name, relationship, phone number, address]?

_____

_____

What supports are you seeking from Assisted Independence? (Circle all applicable)

Day Habilitation - Individual (DHI)

Family and Caregiver Training (FCAR)

Participant Assistance and Care (PAC)

Recreational Therapy (RETH)

Residential Habilitation Services – Level 1 (RH10)

Residential Habilitation Services – Level 2 (RH20)

Respite (RSP0)

Supports

Case Manager Name and Company: _____

Phone Number: _____ Email: _____

When is the next quarterly meeting? (Month/Day/Year): _____ Location: _____

Primary Care Physician (PCP): _____ Name of Doctor's Office: _____

Address: _____ Phone Number: _____ Email: _____

Behavior Management (If Applicable): _____

Phone Number: _____ Email: _____

Residential Service Provider (If Applicable): _____

Phone Number: _____ Email: _____

Medications

Medication Name: _____ Dose: _____ Route: _____

Scheduled time(s): _____ Reason: _____

Prescribing Doctor: _____

Medication Name: _____ Dose: _____ Route: _____

Scheduled time(s): _____ Reason: _____

Prescribing Doctor: _____

Medication Name: _____ Dose: _____ Route: _____

Scheduled time(s): _____ Reason: _____

Prescribing Doctor: _____

Medication Name: _____ Dose: _____ Route: _____

Scheduled time(s): _____ Reason: _____

Prescribing Doctor: _____

Have you ever experienced side effect(s) from any of the above medications? If yes, explain: _____

_____

THE POLICY OF ASSISTED INDEPENDENCE STRICTLY PROHIBITS USE OF ANY PRN PSYCHOTROPIC MEDICATION FOR BEHAVIORAL NEEDS

Are you requesting assistance by Assisted Independence Direct Support Professional (DSP) employees to administer medications? [Note: Assisted Independence employees must have Core A and Core B Medication Administration Training prior to administering medications]: YES or NO

If YES, list medications requiring assistance: _____

_____

Allergies

Please list all allergies and the symptoms of reaction below: _____

_____

Does individual have an Epi-Pen? YES or NO

If YES, please ensure the Epi-Pen is always present when receiving supports.

Does the individual use the restroom independently? YES or NO

If NO, what type of supports are needed when using the restroom? _____

_____

Seizures

Does individual experience seizures? YES or NO

If YES, what type of seizure? _____ Frequency? _____

Date the last seizure occurred: _____ Duration? _____

Does individual have a Vagas Nerve Stimulation (VNS) device? YES or NO
If YES, what side of the chest is the Vagus Nerve Stimulation (VNS) device located? RIGHT or LEFT

Does the individual receive Diastat? YES or NO
If YES, please ensure Diastat is always present when receiving supports.

If YES, is an employee authorized to administer Diastat? YES or NO

Seizure Protocol: _____

_____

Does the individual receiving services have any fears or phobias that employees of Assisted Independence should be aware? YES or NO
If YES, please list: _____

_____

Behavioral

Does the individual exhibit undesirable behaviors? YES or NO

What is the behavior exhibited? _____
How often does the behavior occur? _____ Is the behavior currently being worked on? YES or NO
What behavior is desired to replace the current behavior? _____

_____

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How often does the behavior occur? _____ Is the behavior currently being worked on? YES or NO
What behavior is desired to replace the current behavior? _____

_____

Safety Assessment

Directions: The Safety Assessment is to be completed alongside an Individual Intake Form and annually thereafter. Please, use the Safety Assessment to identify safety risks and opportunities for improvement. Any risks identified from the results of the Safety Assessment are to be addressed during emergency drills, setting goals and objectives, and/or whenever possible.

General Safety

1. Do you feel safe in your home? _____
2. Do you feel safe at work (if applicable)? _____
3. Do you feel safe in your neighborhood? _____

4. Are you able to access running water and adjust the temperature safely? _____

5. Do you spend any time in the kitchen (making your own meals, assisting others)? Do you clean up after yourself? _____

6. Do heating and cooling systems maintain temperature and humidity in a comfortable range?

   _____

7. Does your home have proper ventilation so that air quality is safe? _____

8. Please describe how you keep your home and work environment clean. _____

   _____

9. Do you administer your own medications? Are there any supports you need to ensure medications are taken correctly?

   _____

10. Do you utilize any therapeutic and/or adaptive equipment and is said equipment comfortable and in good repair? Please list all equipment used.

    _____

11. Do you know where the smoke alarms are located within your house? Who is responsible for ensuring alarms are properly maintained?

    _____

12. Do you understand your own personal medical and medication histories? Do you need assistance or reminders in tracking upcoming medical appointments?

    _____

13. Do you feel you have adequate supports to ensure your personal safety? If not, what areas of support would need to be improved?

    _____

Emergency Procedures

14. In the event of severe weather (such as tornado or flood), are you able to promptly evacuate to safety? What is your safety plan currently in place?

    _____

    _____

15. In the event of a fire in the home, are you able to independently evacuate to safety? What is your safety plan currently in place?

_____

_____

16. Do you have a fire extinguisher in your home? Where is it located?

_____

_____

17. In the event of an emergency of any nature, are you able to call for help? Who do you call for help and how do you call for help?

_____

Expectations

1.) Assisted Independence is not able to provide supports to individuals who are ineligible for the Medicaid Family Support Waiver (FSW) or Community Integration and Habilitation Waiver (CIHW) unless a private payment agreement is in place between the two parties. Assisted Independence will do our best to continue support without interruption after a brief period ineligibility. If the individual is ineligible for a given time frame, the individuals will be placed at the top of the waitlist upon updated eligibility.
2.) Assisted Independence employees often drive from one individual to another. Please allow for a 15 minutes time of arrival window for scheduled sessions.
3.) Services provided by Assisted Independence may take place in the community. As the individual/parent/guardian, you have the right to choose whether or not to accept transportation from the employee of Assisted Independence.
4.) According to Indiana Administrative Code (IAC) 460-6, employees of Medicaid waiver supports are NOT permitted to spend money on behalf of individuals supported. This includes meals, entry into activity sites, or any other fees associated with support provided. An emancipated individual or the parent/guardian of the individual incurs all consented costs in the community independently.
5.) If participating in applicable activities offered with or by Assisted Independence, the individual/parent/guardian is obligated to provide the following, including, but not limited to, food, water, hygiene products, bugspray, sunscreens, lip balms, lotions, clothing, swimsuits, gym shoes, medical supplies (catheters, lubrications, colostomy bags, feeding tubes, eyedrops, etc.), or any other necessary personal product for the health, safety, and wellbeing of the individual.
6.) According to Division of Disability and Rehabilitative Services (DDRS) policy, any total number of session cancellations equaling to 25% or more of the scheduled session could result in a loss of services.
7.) Assisted Independence employees are NOT responsible for taking care of any pets owned or at the premises of the home of an individual supported at any point in time. Assisted Independence requires those receiving supports from Assisted Independence at a home (individual, family, or support living site) to disclose knowledge of all pets and/or animals on the premises in order to ensure Assisted Independence provides an employee that does not have allergies to the known pet or animal.
List of Pets/ Animals: _____
8.) Assisted Independence encourages those receiving supports to obtain a picture identification card. The Indiana Bureau of Motor Vehicles (BMV) may provide a driver's license identification card with purchase. Two of the following are required to obtain a driver's license identification card Social Security Card, Certified U.S. birth certificate, U.S. passport, Certificate of Naturalization, Certificate of Citizenship, U.S. Certificate of Birth Abroad, Resident Alien Card, or Valid foreign passport with valid U.S. immigration document.
9.) In the event an employee of Assisted Independence is terminated, administrative staff at Assisted Independence will do our best to inform the individual/ family of the employee's termination prior to the termination. In the

event an employee is terminated, it is recommended to change all home and personal passcodes and locks for which the terminated employee has access.

10.) Assisted Independence recognizes the following occurrences that may warrant an immediate in-person or phone-call response: anytime alleged, suspected, or actual abuse, neglect, or exploitation occurs, anytime injury occurs, anytime death occurs, anytime a structural or environmental problem threaten the health and safety of the individual, anytime a fire occurs at the individual's whereabouts, anytime a first responder, police officer, fire fighter, or EMT arrives to individual's home, anytime elopement occurs, or the individual wanders without telling somebody, anytime alleged, suspected, or actual criminal activity by an employee of Assisted Independence occurs, anytime a medication error occurs, anytime a medication side effect occurs that warrants immediate attention, anytime a physical or mechanical restraint is used, anytime the individual has a fall, any unusual incident that may effect the health, wellness, and functioning of the individual, anytime a medical appointment, such as doctor's appointment, psychiatry appointment, or therapy appointment is scheduled, and was not able to be attended during a scheduled shift, anytime a behavioral related incident occurs that results in potential self-harm, harm to others, or property damage, anytime a threat is made towards the individual, anytime a vehicular accident involving the individual occurs, anytime staff has verbally agreed or committed to seeing the individual and not done so, anytime another scheduled staff is unable to fulfill a scheduled shift, anytime an unexpected visitor arrives to the individual's residence, anytime a severe, adverse weather event, such as a tornado or flood, occurs, anytime an electricity outage occurs, anytime a terror threat or act occurs in individual's vicinity, any "act of God" or severe adverse event that were to pose a serious threat to the individual, anytime an animal enters individual's household unexpectedly, and the animal does not leave willingly. Any occurrences not listed above that request attention should be withheld from communication until Assisted Independence normal business hours. We kindly ask that if the communication can be delivered via email, that be the chosen mode.

Current Photo

According to Indiana Administrative Code (IAC) 460-6, the individual's personal file shall contain a photograph of the individual, if a photograph is available; and inclusion of a photograph in the individual's file is specified by the individual's PCISP

Please note the times and days of any reoccurring conflicts to scheduling:

Monday:	**Tuesday:**

Wednesday:	**Thursday:**
Friday:	**Saturday:**

Additional Notes: (for relevant information not covered in form)