

3. Primary Language (communication skills)

- English
- Spanish
- American Sign Language
- Symbolic (type_____)
- Communication Device
(type_____)
- Non-verbal
- Other_____

Secondary Language (communication skills)

- English
- Spanish
- American Sign Language
- Symbolic (type_____)
- Communication Device
(type_____)
- Non-verbal
- Other_____

Communication Abilities:

- effectively communicates wants/needs
- can carry on a conversation
- utilizes alternative communication (specify):_____
- needs a translator (specify person/agency):_____
- needs prompting/cueing to initiate communication
- has difficulties with articulation/speech
- needs prompting/cueing to engage in conversation

4. Does this applicant have a court appointed guardian or custodian? No, Yes.

If yes, Please list below and attach documentation:

Name: Last _____ First _____ M _____

Relationship: Parent, Guardian, Spouse Other _____

Current Address: Street _____

City _____ State _____ Zip _____

Home Phone: (____) _____ Cell:(____) _____ Work Phone: (____) _____

Email: _____

5. Primary Health Care Provider

Primary Physician: _____

Street _____

City _____ State _____ Zip _____

Office Phone: (____) _____ Fax:(____) _____

Hospital Affiliation: _____

6. Name, Service Coordinator: _____

Agency Affiliation: _____

Street _____

City _____ State _____ Zip _____

Office Phone: (____) _____ Fax:(____) _____

Email: _____

7. Does this applicant have any known allergies, for example, to foods, medications, or the environment? No, Yes. If yes, please list below:

8. **Has this applicant ever been convicted of a felony?** No, Yes. If yes, please list below:

The applicant is currently on probation parole for the following charge:

List any specific conditions of parole/probation: _____

Probation/parole is expected to end on: _____

9. **Does the applicant have a DNR order?** No, Yes. If yes, attach a copy to this form.

Does the applicant have a Health Care Proxy? No, Yes. If yes, attach a copy to this form.

Name of Health Care Proxy: _____

Name of Alternate Health Care Proxy: _____

Does the applicant have a Living Will? No, Yes. If yes, attach a copy to this form.

Does this applicant have a Power of Attorney? No, Yes. If yes, attach a copy to this form.

Name of Power of Attorney: _____

10. **Describe the reason(s) this applicant is requesting services from PRALID.**

(Please attach separate sheet if necessary. Please do not state "refer to ..." another document.)

11. **Describe this applicant's disability history.** Please include any special medical or mental health issues in the history. (Please attach separate sheet if necessary. Please do not state "refer to..." another document.)

Height _____

Weight _____

Primary Diagnosis _____

Secondary Diagnosis _____

Comprehension Ability:

comprehends verbal directions without problems

understands simple directions

does not understand simple directions

understands Sign Language

other, please describe: _____

12. Does the applicant have a history of behavioral challenges or current behavior plan?

No, Yes. If yes, please complete the following:

- a. Will this plan need to be utilized while the consumer is receiving services?
 No, Yes If yes, please attach the plan, a consent and addendum stating that the plan applies to the service the consumer will be receiving at PRALID.
- b. What specific behaviors does the plan address? (ex: Biting, aggression, PICA, SIB)
- c. What triggers these behaviors?
- d. How long has the plan been in place?

13. School/Program Information:

Is the applicant attending school or a day program? No, Yes. If yes, please list below:

School or Program Name: _____

Contact Name: Last _____ First _____ MI _____

Address: Street _____

City _____ State _____ Zip _____

Contact Phone Number: (____) _____ Work Phone: (____) _____

Transportation Provider: _____

Transportation Contact: Last _____ First _____

Contact Phone Number: (____) _____

14. Has this applicant ever had a seizure? No, Yes If yes, please answer the following:

a. When was the last time the applicant had a seizure? _____

b. How often does the applicant have a seizure? _____

c. Please describe, as fully as possible, a typical seizure episode, including physical characteristics and duration. Describe any warning signs that a seizure is about to occur.

d. How often does the applicant see the physician who treats their seizures? _____

e. Is the applicant taking medication(s) to control their seizures? No, Yes

f. If yes, what medication(s) is the applicant taking to control their seizures? _____

15. Cognitive Status: (please check all that apply)

Orientation: Oriented to: time place person activities day/week
 needs prompting/cueing for orientation easily confused not oriented

Attention/Concentration: able to stay on task independently easily distracted
 needs occasional verbal cues/prompts to stay on task requires constant cueing/prompting

Initiation: initiates activities requests assistance when needed ability varies for ADLs
 needs cues/prompts to initiate tasks/activities cannot initiate tasks/activities

Memory: memory is functional for day-to-day activities short term memory difficulties
 long term memory difficulties

Organization: good organizational skills ability varies based on task/activity
 needs prompting/cueing for organizational skills needs others to provide organization

Problem-Solving/Judgment: aware of current skills/limitations makes reasonable decisions
 needs cues/prompts for problem-solving unable to engage in problem-solving activities

Learning abilities: able to follow one-step directions able to follow multi-step directions
 interested in and willing to learn new strategies/tools not able to follow directions

Other details regarding cognitive status:

16. Social and Recreational Activities

- a. Describe how the applicant interacts with peers, younger children, and authority figures.

- b. Describe the applicant's favorite activities/hobbies? What supports or supervision are needed to participate in these activities?

- c. Are there any special concerns when the applicant is in the community (on an outing for example). What supports or supervision are needed to participate in these activities?

d. Does the applicant have any special travel needs such as a wheel chair, person to accompany them, special accommodations, or supervision? What supports or supervision are needed to participate in these activities?

e. Does the applicant need transportation to get to and from services? No, Yes If yes, please describe.

f. Does the applicant have the ability to understand and handle money?
Handling limit _____

17. Dietary Regulations: (check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Low Sodium | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Low Cholesterol |
| <input type="checkbox"/> Diabetic Diet | <input type="checkbox"/> Renal Diet | <input type="checkbox"/> Cardiac Diet | <input type="checkbox"/> Nutritional Supplement |
| <input type="checkbox"/> Swallowing Difficulties | <input type="checkbox"/> Pureed Foods | <input type="checkbox"/> Ground Consistency | |
| <input type="checkbox"/> Chopped Consistency | <input type="checkbox"/> Thickened Liquids | <input type="checkbox"/> Tube Feeding | <input type="checkbox"/> Adaptive equipment |
| <input type="checkbox"/> Aspiration Precautions (if checked please explain): _____ | | | |

- Dentures: Upper Lower Partial
 Special Dietary Considerations (e.g. vegetarian, kosher, etc.) specify: _____

Describe any specific information that pertains to the applicant's ability to eat and drink:

18. Mobility:

Mode of Ambulation: independent cane walker wheelchair scooter unable

Ability to Ambulate: independent needs periodic supervision/oversight
 needs ongoing supervision/oversight one person assist two-person assist unable

Ability to Transfer: independent needs periodic supervision/oversight
 needs ongoing supervision/oversight
 one person assist two-person assist unable
 mechanical lift other

20. What is the applicant's evacuation capability? Is the applicant able to safely evacuate any structure by themselves?. No, Yes If no, what type of support/assistance is needed?

21. ADLS/IADLS:

Basic ADLs (Eating, Dressing, Toileting, etc.): independent needs verbal cues/prompts
 needs physical cues/prompts needs hands-on assistance needs total support

Is this applicant continent of bowel? No, Yes
Is this applicant continent of bladder? No, Yes

If *No* to either question, please describe toileting needs and routines, including the use of adult continence products.

Will the applicant ask for toileting assistance? No, Yes
Will the applicant be aware if he or she is incontinent? No, Yes

Household Activities (Meal Prep, Laundry, etc.): independent needs verbal cues/prompts
 needs physical cues/prompts needs hands-on assistance must be completed by others

IADLs (Shopping, Banking, etc.): independent needs verbal cues/prompts
 needs physical cues/prompts needs hands-on assistance must be completed by others

Endurance/Strength: able to engage in routine activities
 experiences periodic fatigue fatigues easily requires frequent rest periods
 needs physical assistance to engage in routine activities

22. Durable Medical Equipment:

Supply or Equipment Item	Purpose of Equipment	Prescribed By and Phone Number

23. Hearing Ability:

Hears adequately Hearing difficulty Uses Hearing Aid
Hearing Impairment Effects: Right Ear Left Ear
 Other devices used: _____

Describe any specific information that pertains to the applicant's ability to hear:

24. Visual Ability:

Vision is adequate for daily activities
 Visually Impaired Right Eye Left Eye Wears Glasses Needs Large Print

- Cataracts Right Eye Left Eye
 Blind Right Eye Left Eye Uses Braille
 Eye Prosthesis Right Eye Left Eye
 Guide Dog
 Other: _____

Describe any specific information that pertains to the applicant's vision:

25. Medication Regimen: *Please list all current medications.*

Medications (prescription and over-the-counter)	Dosage	Route (injection, oral, etc.)	Frequency	Purpose	Prescribing MD

26. Special Needs for Medications.

- a. Does this applicant have any special needs to enable them to take medication, such as taking the medication in pudding, applesauce, etc? This may be such things as taking the medication with a special food, with a special cup or spoon, or in a special way.
 No, Yes If yes, please describe those special needs.

- b. Is this applicant capable of self medication administration? No, Yes. If yes, please describe any special needs and supports needs by this applicant for self medication administration.

Physicians:

Neurologist

Dr. _____
First MI Last

Office Address

City State Zip Office Phone

Other Physician: Discipline: _____

Dr. _____
First MI Last

Office Address

City State Zip Office Phone

Other Physician: Discipline: _____

Dr. _____
First MI Last

Office Address

City State Zip Office Phone

Other Physician: Discipline: _____

Dr. _____
First MI Last

Office Address

City State Zip Office Phone

Thank you for completing this form.

Print Name of Person completing this form _____

Relationship to Applicant _____

Signature of person completing form_____

Phone Number (____)_____

Email Address: _____

Once completed please forward to:

**PRALID, Inc.
Admissions Development Coordinator
2 Townline Circle
Rochester, NY 14623
(585) 442-6420
Fax: (585) 442-6964**