Individual Name: _____
Date of Referral:_____

Crowhaven: Individual Assessment and Application

This form will be utilized by the Crowhaven Manager (or designee) during the initial meeting/ tour with the individual, to assist in determining if the individual's needs and preferences can be met.

Demographic/Identifying Information*

First Name	Middle Name	Last Name	
Address	City	State	Zip Code
Current Phone	DMH ID #	Social Security Number	
Date of Birth	Age	Gender	
Height	Weight	Hair Color	
Eye Color	Other Identifying Characteristics		
	Current Living Arrangement		
	• Apt/House • Shelter/Halfway House • Psychiatric Institution • Nursing Home/Assisted Living • Homeless Shelter • Acute Hospital Care • RCF		
Blood Type (if known)	Active Diagnoses (Attach Primary Documentation)		

Responsible Party Information

Guardian Information*

First Name	Middle Name	Last Name	
Address	City	State	Zip Code
Phone Number	Email Address		
Fax Number	Emergency Phone	Relationship to Individual	
Type of Guardianship	• Full • Limited • Medical Only • Durable Power of Attorney • Other: _____		
If guardian is Public Administrator, who is the best contact? (ie: Deputy Name)			

Payee Information (If Applicable)*

Name of Person or Entity			
Address	City	State	Zip Code

Phone Number	Email Address

Service Coordinator Information*

If the individual is NOT active with the Regional Office, please check here: _____

Name of Service Coordinator			
Address	City	State	Zip Code

Phone Number	Email Address
Fax Number	Agency/Organization of Employment
Waiver Slot Number	Waiver Type

Current Services*

Service	Provider
Speech/Language	
Occupational Therapy	
Physical Therapy	
ABA	
Counseling	
Community Integration	
Other	

Individual Name: _____
Date of Referral:_____

Insurance Information*

Medicaid Number		Effective Date of Coverage	
Medicare Number		Effective Date of Coverage	
Other Insurance Company	Membership ID	Group Number	Effective Dates of Coverage
Name of Policy Holder		Date of Birth of Policy Holder	

Personal Contacts*

Family/Friends/Significant Other, etc.			
Name	Relationship	Contact Number	Special Instructions

Medical Contacts*

Current Consulting Physicians/Specialists				
Name	Specialty	City	Phone	Will continue to see?
	PCP			
	Dentist			
	Vision			
	Neurologist			
	Psychiatrist			

Service Goals*

What are the short term goals while living at Crowhaven?
What are the long term goals while living at Crowhaen?
What is the individual/team's definition of independence? How will this look in the individual's life?

Communication:*

Mode	• Verbal • Partially Verbal • Gestures/Non-verbal • Assisted • Non-Communicative
Quality Expressive	• Clear and easily understood • Difficult to understand • Unintelligible
Quality Receptive	• No deficits noted • Appears to have difficulty understanding • Unable to comprehend at a functional level
Hearing	• Facilitates conversation at normal levels • Deficit noted • Deaf
Current Supports	• Communication Board • Picture Book • Communication Grid • Sign language • Written communication • Hearing Aid
Primary Oral Language	Primary Written Language
Comments:	

Mobility:*

Fall Risk	• Yes • No
Mobility	• Walks on own • Walks with assistance • Uses walker • Uses a cane • Wheelchair • Other

Medical History*

- Anemia
- Bleeding/ Clotting Disorder
- Blood Clots
- Blood Sugar Disorder
- Diabetes
- High Cholesterol
- Cancer (Type: _____)
- Heart Attack
- Dizziness
- Fainting Spells
- Heart Disease
- Heart Murmur
- High Blood Pressure
- Swelling of feet or legs
- Numbness/ Tingling
- Change in Menstrual Pattern
- Extremely Painful Menses
- Heavy Menstrual Flow
- Allergies
- Chicken Pox
- Hepatitis A, B, or C
- Measles
- Mumps
- STDs
- Arthritis
- Broken Bones
- Chronic Pain
- Paralysis
- Osteoporosis
- Decubitus Ulcer/ Skin Breakdown
- Frequent or painful urination
- Difficulty urinating
- Gall Bladder Problems
- Hemorrhoids
- Hernia
- Kidney Problems
- Liver Disease
- Thyroid Disorder

If any of the above are checked, provide details including date(s) of diagnosis and interventions, and continued supports required:*

Level of Supervision and Support*

Within the Home

- No Supervision
- Known Whereabouts
- Regular Checks (_____ minutes)
- Supervision for Personal Care
- Assistance for Personal Care
- Assistance for Everything
- Line of Sight
- Arm's Length
- Other: _____ _____

Outside of the Home/In the Community

- No Supervision
- Free Time (____ minutes)
- Known Whereabouts
- Regular Checks (_____ minutes)
- Line of Sight
- Arm's Length
- Specific Distance
- Other:

  _____
  _____

Anticipated Level of Support for Activities of Daily Living*

Meal Preparation	• Requires assistance with menu planning • Independent and safe for basic meals requiring cooking • Independent and safe for meals not requiring cooking • Verbal cues required for cooking • Verbal prompts required for cooking • Hand over Hand support for cooking • Total support for meal preparation
Toileting Toileting	• Continent • Occasional Incontinence • Incontinent • Wears depends • Catheter/Ileostomy/Colostomy • Independent • Visual cue • Verbal Prompt • Hand over hand • Total support
Hygiene (to include bathing, teeth, hair, nails, dressing, etc.)	• Independent • Visual Cue/Schedule • Verbal Prompts • Hand over Hand • Total Support
Household Chores (to include laundry, cleaning, etc)	• Independent • Visual Cue/Schedule • Verbal Prompts • Hand over Hand • Total Support
Management of Personal Finances	• Independently maintains PSA • Requires assistance with budgeting • Requires assistance with maintaining security of personal funds • Requires assistance with purchases • Limitations on access to funds: _____ _____

Safety*

Use of Household Chemicals	• Safe and appropriate use independently • Requires supervision during use • Cannot use even with supervision • Must be locked to ensure safety
Use of Sharps	• Safe and appropriate use independently • Requires supervision during use • Cannot use even with supervision • Must be locked to ensure safety
Response to Emergency Situations	• Able to utilize the phone to notify EMS appropriately • Knowledge of response to tornado • Knowledge of response to fire • Knowledge of response to violent/ threatening situation • Interacts appropriately with strangers • Knowledge of pedestrian safety • Safe when riding in vehicles

Behavior Supports*

Does the consumer exhibit any of the following:

Physical Aggression	• Towards self • Towards others • Towards animals
Fire-Setting	• Yes • No
Sexually Inappropriate Behavior	• Verbal statements • Self-stimulation in public • Groping/inappropriate contact with others • Perpetration • Attraction to minors

Property Damage	• Minor • Major ($1,000 or more per month) • Personal belongings only

Vocational Goals*

Briefly describe work history	
Desired Employment	• Full Time • Part Time • Competitive • Work Team • Sheltered Workshop • Day Program • No desire for employment
Follow-Up Action Required	• Referral to VR • Referral to DMH Employment Services • Assessment Required • Supports to be developed outside of Supported Employment Services

If Referral is ACCEPTED:

Proposed Service(s)	Service Code	Units	Start Date

Individual Name: _____
Date of Referral:_____

If the Referral is DECLINED:

Reason for declination:		
Recommendations:		
Person Notified:		**Date Notified:**