Easterseals Crossroads Intake Form

CLIENT INFORMATION

Emancipated? ☐

First Name: _____ Middle Initial: _____ Last Name: _____

Chosen/Preferred Name: _____ Date of Birth: _____

Sex: ☐Male ☐Female ☐Non-Binary ☐Prefer Not to Answer SSN (last 4):

Street Address:

City: State: Zip Code:

Home Phone^: Cell Phone^: Work Phone^:

Email^: Preferred Contact Method?^ ☐Phone ☐Email

ADDITIONAL CONTACT INFORMATION

Primary Contact Name: Primary Contact Phone:

Primary Contact Email:

What email should be used for the Client Portal (online access to documents, messages, signing documents, and paying invoices):

PARENT/GUARDIAN INFORMATION

Guardian First Name: Guardian Last Name:

Guardian Street Address*:

City*: State*: Zip Code*:

Home Phone*: Cell Phone*: Work Phone*:

Email*: Preferred Contact Method?* ☐Phone ☐Email

Is the guardian above a parent of the client? ☐Yes ☐No Are they a legal guardian?** ☐Yes ☐No

Additional Guardian First Name: Guardian Last Name:

Guardian Street Address*:

City*: State*: Zip Code*:

Home Phone*: Cell Phone*: Work Phone*:

Email*: Preferred Contact Method?* ☐Phone ☐Email

Is the guardian above a parent of the client? ☐Yes ☐No Are they a legal guardian?** ☐Yes ☐No

If an individual has Legal Guardianship, court papers must be presented to maintain on file

^Complete if client is an adult/emancipated minor
*Complete if different from above

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CLIENT MEDICAL INFORMATION - RELATED TO SERVICES

Current diagnoses (if none, write "none"): _____

_____

Primary Care Provider's (PCP) name:

PCP's phone number:

PCP's office address:

Hospital preference:

Preferred language:

Interpreter desired (if yes, note language needed):

SERVICES SOUGHT

- ☐ ABA Therapy
- ☐ Assistive Technology
- ☐ CampAbility
- ☐ Camp FUEL
- ☐ Camp MODE
- ☐ Camp ROCKS
- ☐ Clinical Mental Health
- ☐ Day Program
- ☐ Diagnostic Clinic
- ☐ Employment Services
- ☐ Friday Night Out
- ☐ iCan Bike
- ☐ Occupational Therapy
- ☐ Parents' Day Out
- ☐ Parents' Night Out
- ☐ Physical Therapy
- ☐ Recreation Therapy
- ☐ Resource Facilitation/TBI
- ☐ Speech Therapy
- ☐ Teen Night Out
- ☐ Veterans Services
- ☐ Augmentative Communication

AVAILABILITY FOR SERVICES

What time(s) are you available to receive services each week?

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time(s) Available							

Continued on the next page...

PAYOR INFORMATION

☐ Commercial Insurance
☐ Medicaid
☐ Non-Waiver BDDS Services (State Line Item)
☐ Social Security Administration
☐ School or School District (Name of School or School District:)
Payor Contact Name (e.g., VR Counselor, Case Manager, etc.):
☐ Indiana Vocational Rehabilitation
☐ Medicaid Waiver
☐ Private Pay/Self Pay

INSURANCE INFORMATION – IF USING TO PAY FOR SERVICES

Primary Insurance: ☐ Commercial ☐ Medicaid ☐ Waiver ☐ None/Not Applicable

Insurance Carrier:

Subscriber's Full Name: Subscriber's Date of Birth*:

Subscriber's Gender*: Subscriber's Social Security Number*:

Insurance ID Number: Group Name/Number:

Subscriber's Address**:

Client's Relation to Subscriber (e.g., self, child, spouse, etc.):

Secondary Insurance: ☐ Commercial ☐ Medicaid ☐ Waiver ☐ None/Not Applicable

Insurance Carrier:

Subscriber's Full Name: Subscriber's Date of Birth*:

Subscriber's Gender*: Subscriber's Social Security Number*:

Insurance ID Number: Group Name/Number:

Subscriber's Address**:

Client's Relation to Subscriber (e.g., self, child, spouse, etc.):

Tertiary Insurance: ☐ Commercial ☐ Medicaid ☐ Waiver ☐ None/Not Applicable

Insurance Carrier:

Subscriber's Full Name: Subscriber's Date of Birth*:

Subscriber's Gender*: Subscriber's Social Security Number*:

Insurance ID Number: Group Name/Number:

Subscriber's Address**:

Client's Relation to Subscriber (e.g., self, child, spouse, etc.):

*Complete if the Subscriber is not the client
**Complete if different from information on the first page

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DEMOGRAPHIC INFORMATION

The questions below ask for demographic information about the client we will be serving and their household. All questions below are optional and can be answered by selecting "Prefer not to Answer" if you do not wish to disclose. The information provided will be used to support Easterseals Crossroads in applications for grants to assist in funding our services. Individual responses will not be disclosed to outside entities and will be held confidential within the organization. Your answers to the below questions will not affect services delivered by Easterseals Crossroads.

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Trans-Male ☐ Trans-Female ☐ Prefer not to Answer

Client's Race (select all that apply): ☐ Prefer not to Answer

☐ African American or Black
☐ Caucasian
☐ Pacific Islander or Native Hawaiian
☐ Asian
☐ American Indian or Alaskan Native
☐ Other: _____

Client's Ethnicity (select one): ☐ Prefer not to Answer

☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Client's Household Annual Income (select one): ☐ Prefer not to Answer

☐ Less than $10,000
☐ $10,000 - $20,000
☐ $20,000 - $30,000
☐ $30,000 - $40,000
☐ $40,000 - $50,000
☐ $50,000 - $60,000
☐ $60,000 - $70,000
☐ $70,000 - $80,000
☐ $80,000 - $90,000
☐ $90,000 - $100,000
☐ Greater than $100,000

Number of Individuals in the Household: _____ ☐ Prefer not to Answer

Client's Highest Level of Education (select one): ☐ Prefer not to Answer

☐ Less than High School
☐ High School/GED
☐ High School Equivalent
☐ Certificate of Completion
☐ Some College
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctoral Degree

Client's Employment Status: ☐ Prefer not to Answer

☐ Full Time (35+ hours/week)
☐ Part Time (less than 35 hours/week)
☐ Unemployed (seeking employment)
☐ Not in the workforce (homemaker, disabled, retired, student, child, etc.)

EASTERSEALS USE ONLY

Entered into CR? ☐ Form Used: _____
By Whom: _____ Date Entered: _____
Referral Date: _____ Referral Source: _____
Referral Source Contact Information: _____
Primary Service Location (select one): ☐ North Office ☐ South Office ☐ Community
Add On Form(s) Used: _____

ADDITIONAL CLIENT INFORMATION

Client Name: _____

Pronouns that should be used to refer to the client:

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Something else: _____

Allergies (medications/food/environmental/insect): _____

The client requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.): ☐ Yes ☐ No

If yes, please provide additional information: _____

SUPPORT PLANS

The client has the following support plans in place, and I have attached them to this registration form:

☐ Individualized Education Plan ☐ Behavior Support Plan ☐ Individual Support Plan
☐ Seizure Management Plan ☐ Other: _____ ☐ N/A; Reason: _____

LEVELS OF CARE

The following information will inform the level of care needed and how Respite staff can best support the client at each Respite event.

Toileting:

☐ Reminders
☐ Assistance with clothing
☐ Assistance after a bowel movement
☐ Fully independent
☐ Diapers
☐ Assistance with washing hands
☐ Assistance transferring on/off toilet

Please Provide Additional Information:

_____

_____

Ambulation/Risk of Falling:

☐ Use of wheelchair
☐ Use of prosthetics/orthotics
☐ Requires assistance ambulating/transferring
☐ Other: _____
☐ Risk of falling due to instability
☐ Risk of falling due to seizures
☐ Client is fully ambulatory

Please Provide Additional Information:

_____

_____

Medication Administration:

☐ Client will require medication administration while at Respite events
(if yes, you need to fill out a medication administration form at sign in each time you attend a respite event)
☐ Client will have PRN medication (e.g., inhaler, melatonin, diastat, epi-pen) at Respite events
☐ Client will not require medication administration while at Respite events

Please Provide Additional Information:

_____

_____

Social Preferences:

☐ Large Group – Client will engage in large group activities with Respite staff (5-7 clients)
☐ Small Group – Client will engage in small group activities with Respite staff (2-4 clients)
☐ One-on-One – Client will always require one-on-one support from Respite staff
How does the client respond to new environments? _____

Leisure Activities:

Please check all activities that the client enjoys participating in:

☐ Outside/Playground	☐ Video Games/Electronics	☐ Gym
☐ Arts/Crafts	☐ Movies	☐ Painting/Coloring
☐ Sports	☐ Pretend Play	☐ Board Games
☐ Reading Books	☐ Music/Dancing	☐ Other: _____

Please Provide Additional Information:

_____

_____

Communication:

Please check all that apply for how the client communicates needs and/or if help is needed:

☐ Requests items by pointing or gestures	☐ Vocalizations/sounds/cries
☐ ASL	☐ Writing/Visual Schedules/Word Cards
☐ Communication Device	☐ Unable to effectively communicate needs

Please Provide Additional Information:

_____

_____

Nutrition/Feeding:

Please check if the client requires any of the following:

- ☐ Special preparation of food (e.g., pureed, soft, cut into small pieces, etc.)
- ☐ Food allergies
- ☐ G-tube feedings
- ☐ Bottle feeding
- ☐ Assistance opening packages
- ☐ Snack will be provided by parent/caregiver
- ☐ Diabetic
- ☐ Diet restrictions
- ☐ Choking risk
- ☐ Assistance with feeding/using utensils

Please Provide Additional Information: _____

_____

Sensory Needs:

Please describe any sensory fears/discomforts (e.g., thunderstorms, sounds/loud noises, hot/cold, etc.):

_____

_____

Please describe any sensory preferences (e.g, chewy toys, ear protection, light-up objects, etc.):

_____

_____

Behaviors:

Please provide information on the client for the following areas and how staff should redirect the client if behaviors are exhibited.

Aggression Towards Self (i.e. scratches, pinches, bangs head, pulls hair, etc.):

_____

_____

Aggression Towards Others (i.e. scratches, pinches, hits, grabs others, etc.):

_____

_____

Runs Away/Risk of Elopement:

_____

_____

Disrobing:

_____

_____