New Participant Intake Assessment Form

Date: _____

Participant Name: _____

Participant Birthdate: _____

1. Mobility:
   - ☐ Able to Walk Unassisted
   - ☐ Able to Walk with Assistance
   - ☐ Confined to a Chair
2. Communication:
   - ☐ Verbal
   - ☐ Non-verbal
   - ☐ Communication Device
3. Toileting needs:
   - ☐ Independent
   - ☐ Needs Some Assistance
   - ☐ Needs Full Assistance
4. Eating:
   - ☐ Independent
   - ☐ Needs Assistance
   - ☐ Choking Risk
   - ☐ Tube Fed
5. Please describe any behavioral issues, if any. Please include any extreme anxiety, sensory issues, aggression, specific triggers and/or difficulties in a group setting.

6. Describe any food allergies and/or medical conditions that need intervention.

7. Program(s) interested in:
   - ☐ Facility Based Skill Building (onsite)
   - ☐ Community Based Skill Building (trips into the community)
   - ☐ Supported Employment
8. Days interested in attending (check all that apply):
   ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
9. Desired date participant is available to begin attending: _____
10. Does participant have Medicaid? ☐ Yes ☐ No

Which Agency: ☐ MORC ☐ CLS ☐ MCCMH ☐ OCHN

Other: Please list _____

If yes, Supports Coordinator name and email:

_____

Parent/Guardian

Name: _____

Address: _____

Phone #: _____

Email Address: _____

Preferred form of contact:

☐ Phone ☐ Email ☐ Text (# to text): _____

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