Cobblestone Arts Center

Individual's Name: _____

Date of Birth: _____

Address: _____

_____

Phone Number: _____

Legal Guardian: _____

Legal Guardian Phone Number: _____

Legal Guardian Email Address: _____

Medicaid #: _____

Tabs ID #: _____

Care Coordinator/Manager: _____

Care Coordinator/Manager Email: _____

Care Coordinator/Manager Phone: _____

Is the Student aging out of High School? Yes ___ No ___

School District (if applicable): _____

Programming Interests:

- ☐ Site-based
- ☐ Dayhab Without Walls (DWOW)

Desired Start Date: ___/___/_____

Is transportation needed? Yes ___ No ___

Days Attending (check all that apply):

M ___ T ___ W ___ TH ___ F___

Cobblestone Arts Center

Individual Specific Checklist

The following is a checklist of all information needed for the individual PRIOR to admission. ***Missing information may result in a later admission date.*** *Items without a star (*) are only needed if applicable. If you have question about the checklist, please contact megan@cobblestoneartscenter.com.*

- ☐ Intake/Referral Packet fully completed*
- ☐ NOD/Program Approval*
- ☐ Current Life Plan*
- ☐ Annual Physical Exam*
- ☐ Immunization Records*
- ☐ 2 PPD (Tuberculosis tests within a year **OR** 1 TB Blood Test)*
- ☐ Current Physician Orders/List of Medications*
- ☐ A successful 3-5 day trial period*
- ☐ Diet Order or Diet Information*
- ☐ Behavior Plan/Supports or Behavior Interventions*
- ☐ School IEP
- ☐ Self-Medication Assessment
- ☐ Socio-sexual Assessment
- ☐ Residential Habilitation Plan (nursing care plan, OT/PT guidelines, Speech)
- ☐ Current Nursing Assessment and Plan of Nursing (DDSO only)
- ☐ Seizure Plan/Guidelines
- ☐ Individual Rights Form (provided during intake)
- ☐ Willowbrook Notice of Rights (for Willowbrook consumers only)
- ☐ Photo Release Form (provided during intake)

Additional Student Information:

Sex: Male Female

Diagnosis: _____

_____

_____

_____

Ethnicity: _____

Parent/Guardian Information:

- *Please indicate if the individual is his/her own guardian by checking here* _____

1. Name: _____

Address: _____

_____

Phone: _____

Email: _____

Employer: _____

2. Name: _____

Address: _____

_____

Phone: _____

Email: _____

Employer: _____

Emergency Contact (in case of an emergency and you are unavailable):

Name: _____

Phone Number: _____

Relationships: _____

Emergency Medical Treatment:

Policy: It is the policy of the Cobblestone Arts Program to obtain authorization for emergency treatment if a parent or guardian is unavailable for consent.

I, _____,

(parent/guardian)

Authorize _____

(hospital)

To provide medical treatment to _____ while he/she is at the Cobblestone Arts Center Program. I authorize the staff at Cobblestone Arts Center to act on my behalf in the event of an emergency.

I also understand that in a life-threatening situation, my family member will be transported to the nearest hospital.

I understand that I, as the primary care giver, maintain my responsibility to pay for both routine and emergency medical care.

I expect to be notified as soon as possible of any emergency situations.

_____ _____

(Parent/Guardian) (Date)

_____

(Relationship to Individual)

Insurance Information (other than Medicaid):

Other Insurance: _____

Subscriber: _____

Group #: _____

Medical Information:

Primary Care Physician: _____

Address: _____

Phone: _____

Health Information:

Height: _____

Weight: _____

Date of last PPD: _____

Allergies: _____

_____

_____

Seizures (Please describe seizure activity and intervention if applicable): _____

_____

_____

Please list any medical conditions and medical history: _____

_____

_____

_____

_____

_____

Will the individual be required to take any medications or emergency medications (Epi-pen, Seizure rescue med, etc.) while at program? ___Yes ___No

Please provide a list of all current medications, dosage, and Rx# including any vitamins, supplements, or over the counter medications. Please list any medications the individual is required to take during program hours. ***If the individual is to receive medication while at program, a current Doctor's order/prescription is required.***

_____

_____

_____

_____

_____

_____

Durable Medical Equipment: _____

_____

_____

How does the individual respond to pain? _____

_____

_____

_____

Can the individual apply simple first aid or identify their need for first aid? _____

_____

_____

Behavior Notations (Please identify all behaviors past and present. Please note that this may impact placement):

Does the individual have a behavior plan or behavior interventions? (Please attach a current copy) ___ Yes ___ No

Please describe specific behavior problems (i.e. hitting, self-injurious behavior, property destruction, aggression, etc.). How are these behaviors handled? _____

_____

_____

_____

Describe any unusual, ritualistic, or routine habits and how they are handled: _____

_____

_____

_____

Does the individual interact appropriately with peers, younger children, authority figures? Describe any concerns. _____

_____

_____

_____

Social/Recreational Activities:

Activities of interest: _____

_____

_____

Activities to avoid: _____

_____

_____

Finance:

Representative Payee: _____

Handling Limit: _____

Transportation:

Please list any special transportation needs including pick up/drop off safety measures:

_____
_____
_____

Activities of Daily Living:

Comprehension:

- ☐ No deficit
- ☐ Understands simple directions
- ☐ Does not understand
- ☐ Understands sign language
- ☐ Utilizes a communication device

_____
_____

Personal Hygiene & Toileting:

- ☐ Independent with toileting
- ☐ Requires assistance with toileting
- ☐ Total care when toileting
- ☐ Wears aiding undergarments (pull up/adult depends)
- ☐ Follows a toileting schedule or protocol

_____
_____
_____

Hand Washing:

- ☐ Independent
- ☐ Needs assistance adjusting water temperature
- ☐ Verbal prompts to complete successfully
- ☐ Requires total assistance

Eating:

- ☐ Independent
- ☐ Needs to be fed
- ☐ Requires adaptive equipment
- ☐ Requires a special diet

_____
_____
_____

Dietary/Eating Guidelines: _____

_____

_____

Drinking:

- ☐ Independent
- ☐ Requires assistance
- ☐ Uses a straw
- ☐ Uses an adaptive cup

_____

_____

_____

Specific food likes: _____

Specific food dislikes: _____

Food Allergies: _____

Safeguards:

Fire Evacuation: _____

Calling for help: _____

Self-Preservation Skills: _____

Levels of Supervision:

Please list what levels of supervision would be in the following environments (Independent, Periodic Checks, Range of Scan).

Classroom/Hallways:

Outside/Yard:

Restroom/Toileting:

Kitchen:

Dining:

Community:

Transportation: ** All individual being transported by Cobblestone Arts Center are classified at Independent with Staff Present due to the driver operating the lift when needed.**

Informed Consent:

Medical: _____

_____

Sexual: _____

_____

Aware of personal rights? _____

Voting Status:

- ☐ Registered
- ☐ Not registered

Individual Goals/Valued Outcomes:

1. _____
2. _____

Other:

Has a SART been completed? ____Yes ____No Date of Approval: _____

Number of units approved _____

Does the Individual utilize self-direction services? ____Yes ____No

Please list any other pertinent information: _____

_____
_____
_____
_____
_____
_____
_____