



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)

Projected 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 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
- Safeguards (Residential or Program)
- Behavior Management/Support Plan
- 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 if applicable): _____

Please list any medical conditions and medical history: _____

Will the individual be required to take any medications 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:

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

Please describe specific behavior problems (i.e. hitting, self-injurious behavior, property destruction, 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 or other communication
-
-

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:

Please list any other pertinent information: _____

