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Today's Date: _____

Consumer Information Pre-Assessment

General Information

Consumer:

Name of Consumer: _____

Date of Birth: _____ Current Age: _____

Gender: _____

Primary Address:

_____

_____

Type of Residence:

- O With family
- O DDSN residential placement
- O Other: _____

Current Diagnoses and Dates of Diagnoses: _____

_____

_____

_____

Medically Diagnosed by: _____ Affiliation: _____

Please attach a copy of diagnosis documentation, if available.

How did you hear about Hope Alive services? _____

_____

Family or Other Support:

Does the consumer have a legal guardian?

- O No
- O Yes

Name: _____

Relationship: _____

Occupation: _____

Employer: _____

Contact information:

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Best Number to Contact: _____

Email Address: _____

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Who completed this questionnaire? _____
Relationship: _____

Other than the guardian listed, does the consumer have any close relationships (i.e., other family members, friends)?

Name	Relationship	Frequency of Contact	Type of Contact (i.e., phone, visits)	How long have they known each other?

Medical Information:

Medications:

Please list any medications that the consumer is currently taking:

Medication Name	Dosage	Start Date

Please list any supplements, vitamins, etc., that the consumer is currently taking:

Medication Name	Dosage	Start Date

Please list any medications that the consumer has previously taken:

Medication Name	Dosage	Length of Time Taken

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Current Medical Conditions:

Please list any current allergies that the consumer may have:

_____
_____
_____

Please list any infectious, contagious, or communicable diseases the consumer may have:

_____
_____
_____

Please list any special nutritional needs or dietary restrictions the consumer may have:

_____
_____
_____

Does the consumer walk independently?

- O Yes
  - With no limitations
  - With an assistive device: _____
  - For limited distances
- O No
  - The consumer manipulates a wheelchair or other device independently
  - The consumer is dependent on others for transportation

Does the consumer have a valid SC driver's license?

- O No
- O Yes

  SCDL number: _____

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Current Treating Physicians:

Doctor's Name	Specialty	Address	Phone Number

Insurance Information (If applicable):

O The consumer does not have insurance.

Name of Insurance: _____
Name of Insured: _____
Social Security Number: _____
Group Number: _____
Certificate Number: _____
Please attach a copy of current insurance card.

DDSN Information (If applicable):

O The consumer does not receive funding from DDSN.

Medicaid Number: _____
Service Coordinator: _____
Service Coordinator's Agency: _____
Service Coordinator's Phone Number: _____
DDSN Waiver Type: _____

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Skills Assessment

Academics

Please check all of the communication systems that best describe the way the consumer communicates:

- O Spoken words
  Comments: _____
- O A communication device (i.e., iPad, Dynavox, etc.)
  Comments: _____
- O Formal sign language
  Comments: _____
- O Informal signs and gestures
  Comments: _____
- O Picture Exchange Communication System
  Comments: _____
- O Gestures or leading a person to a desired item or location
  Comments: _____
- O Engaging in problem behavior to indicate a need
  Comments: _____
- O No consistent system of communication
  Comments: _____
- O Other: _____

Please select the best description of the consumer's education:

- O High school diploma or currently in school without supports – typical classroom
  If this applies, please skip to "Life Skills" on page 8.
- O High school diploma or currently in school – special education classroom
- O Has attended school with supports, but did not graduate
- O Other: _____

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In the boxes below, please check the consistency with which the consumer uses the following skills:

Skill	Usually	Sometimes, but Inconsistent	Rarely or Never
Match objects or pictures			
Imitate actions of others			
Follow directions without visual cues			
Indicate his/her wants or needs without problem behavior			
Imitate sounds or words when modeled			
Label items he or she sees or hears			
Answer questions			
Identify cause and effect relationships			
Speak in sentences			
Participate in conversations			
Ask other people questions (not asking for help or items)			
Identify shapes, colors, numbers, & letters			
Identify locations, occupations, & functions of objects (i.e., the refrigerator keeps things cold)			
Use pronouns, plurals, & prepositions appropriately			
Use a calendar or a schedule appropriately			
Manage his or her own finances/bank account independently			
Pay with cash and coins independently when making a purchase			
Use a credit or debit card independently			
Use a pen or pencil with hand not fisted			
Copy lines and simple shapes			
Write his or her own name			
Use scissors			
Write other words or sentences			

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What are your primary concerns regarding the consumer's academic skills?

_____
_____
_____
_____

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Life Skills

Please check the best description of the level of independence of the consumer with regards to daily living skills:

- O Does not need assistance with the majority of daily living tasks and could likely live independently, or with minimal support
  If this applies, please skip to "Interests" on page 11.
- O Needs assistance with some daily living tasks and likely could not live independently without significant support
- O Needs assistance with most or all daily living tasks

In the boxes below, please check the consistency with which the consumer uses the following skills:

Skill	Usually	Sometimes, but Inconsistent	Rarely or Never
Drink from a cup			
Eat a variety of foods (i.e., fruits, vegetables, meats, grains)			
Use a spoon & a fork to feed himself or herself			
Remove pull-down garments independently			
Remove socks & shoes independently			
Remove shirts independently			
Put on pull-up garments independently			
Put on socks & shoes independently			
Put on shirts independently			
Use the toilet independently			
Take medication independently O Swallows pills O Liquid medication O Crushed or modified pills			
If applicable, complete menstrual care independently			
Brush his or her own hair and teeth			
Make a simple meal using a microwave			
Cross the street safely			

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Skill	Usually	Sometimes, but Inconsistent	Rarely or Never
Locate and retrieve items from a grocery list at the store			
Tolerate a doctor or dentist without problem behavior			
Tolerate assistance with self-help skills when needed			
Identify and use the correct restroom in public			
Read and order desired food from a menu			
Identify and avoid rotten foods or dangerous chemicals			
Respond to his or her name by looking at you			
Make eye contact when speaking to people			
Greet others when they arrive			
Respond to others' emotions appropriately			
Attempt to involve others in something he or she is doing to share interest (not because he or she needs help)			
Observe other people nearby			
Join in with other people in activities or conversation			
Verbally interact with peers			

What are your primary concerns regarding the consumer's life skills?

_____

_____

_____

_____

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Does the consumer have any sensory sensitivities (i.e., sensitivity to loud noises, touch, bright lights, etc.)?

- O No
- O Yes:

_____

_____

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Interests

What are some of the consumer's favorite items or activities?

_____
_____
_____

If known, please list goals the consumer has for himself or herself, or things that the consumer would be interested in doing:

_____
_____
_____

In the boxes below, please check the consistency with which the consumer uses the following skills:

Skill	Usually	Sometimes, but Inconsistent	Rarely or Never
Look at or read books			
Use a computer, iPad, or other electronic device			
Play games alone			
Play games with others			
Construct items using blocks, Legos, or other items			
Play games with rules			
Share or take turns during preferred activities or when using preferred items without engaging in problem behavior			
Engage in leisure tasks appropriately on his or her own for up to 15 minutes			
Accept the removal or transition away from preferred items or activities without engaging in problem behavior			
Accept the answer "no" or "not right now" when he or she asks for a preferred item without engaging in problem behavior			

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Vocational Opportunities

Has the consumer ever held a competitive job?

O Yes

Please describe the position, company, & reason the job ended:

_____

_____

_____

O No, but I would be interested in discussing options related to competitive employment.

O No, and I am not interested at this time.

Has the consumer ever participated in supported employment?

O Yes

Please describe the position, level of support, & reason the job ended:

_____

_____

_____

O No, but I would be interested in discussing options related to supported employment.

O No, and I am not interested at this time.

Has the consumer ever participated in community volunteer work?

O Yes

Please describe the work done, level of support, & reason volunteer work ended:

_____

_____

_____

O No, but I would be interested in discussing options related to volunteer work.

O No, and I am not interested at this time.

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Has the consumer ever participated in a sheltered workshop?

O Yes

Please describe the work done, level of support, & reason the job ended:

_____

_____

_____

O No

Please describe any independent computer skills the consumer may have:

_____

_____

_____

Approximately how long can the consumer typically stay on task without needing prompts or a break?

- O 0-2 minutes
- O 2-5 minutes
- O 5-10 minutes
- O 10-30 minutes
- O Greater than 30 minutes

If you are interested in discussing options related to competitive or supported employment and the consumer has an updated resume, please attach a copy. Vocational opportunities will be managed through Big Brain Staffing (see page 17).

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Experiences

Please describe how the consumer typically spends his or her time throughout the week in the boxes below:

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Morning							
Afternoon							
Evening							

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Challenging Behavior

Type of Behavior	Describe the behavior	What typically happens immediately before the behavior?	How often does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well.	How do you or staff typically respond to this behavior?
Aggression				
Running Away/Eloping				
Self-Injurious Behaviors				
Eating Inedible Objects (Pica)				
Repetitive Vocalizations				
Repetitive Motor Movement				
Ritualistic Behaviors				
Other:				

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Current Treatment and Schedule

In the boxes below, please list any treatments that the consumer is currently receiving.

Type of Treatment	Service Provider or Clinician & Contact Information	Hours Per Week	Start Date	Do you feel that this treatment is beneficial? Please explain.
Regular Education Classroom				
Special Education Placement	O Mixed Special Ed. O Autism Classroom O Partial Inclusion			
Speech Therapy				
Occupational Therapy				
Physical Therapy				
Other ABA Program				
Other:				

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I hereby declare that all information supplied in the above document is true and complete to the best of my knowledge.

I understand that the mission of Project HOPE Foundation, Inc., and all of its programs is to lead the way in serving the autism community by helping families, opening minds, promoting inclusion, and expanding potential.

If the consumer does not have a legal guardian or representative:

_____

Consumer Signature Date

If the consumer has a legal guardian or representative:

_____

Printed name and relationship

_____

Signature Date

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Please return this information to:

Hope Alive
751 East Georgia Road, Suite 100
Woodruff, SC 29388

Fax: 864-476-0033

allisonpetralia@projecthopesc.org

Below are some resources that may be helpful to you:

- Project HOPE Foundation, Inc.: http://www.projecthopesc.org
- Ryan's Law: http://www.autismspeaks.org/news/news-item/%5Btitle-raw%5D-178
- Autism Speaks: http://www.autismspeaks.org
- South Carolina Department of Disabilities and Special Needs: http://ddsn.sc.gov/Pages/default.aspx
- Big Brain Staffing: http://www.bigbrainstaffing.com