Eligibility & Access Interview Packet

Observation Date:_____ **Location:**_____ **Presenter:** _____

Present @ the interview:

☐ **DDA Applicant** ☐ **Other:**_____ **Relation to Applicant:**_____

☐ **Other:**_____ **Relation to Applicant:**_____

Applicant's Participation in Interview_____

☐ **Participated with questions**
☐ **Participated with answers**
☐ **Introduced and then left room**
☐ **Sought attention from caregiver**
☐ **Stayed in the room**
☐ **Not able to contribute in any way**

Applicant Demographics and Information

Legal Name: _____

Date of Birth / Age:_____ Social Security #: _____

Medical Assistance #:_____ Medicare #:_____

- If applicant does not have Medicaid, have they applied? ☐ YES ☐ NO
  If YES: When? _____ Where?_____
  If NO: Were directives/information given for the applicant to apply? ☐ YES ☐ NO

Other Health Insurance? _____

Family Information

Name/Relationship	DOB	Health Concerns/Disabilities	Live in home
Mother:_____	_____	_____	☐
Father:_____	_____	_____	☐
Other: _____	N/A	_____	☐
Other: _____	N/A	_____	☐
Other: _____	N/A	_____	☐
Other: _____	N/A	_____	☐

Medical Information

Please describe any medical conditions that you have been diagnosed with:

When/How Identified:

- ☐ Autism _____
- ☐ Cerebral Palsy _____
- ☐ Epilepsy/Seizure Disorder _____
- ☐ Head Injury _____
- ☐ Intellectual Disability _____
- ☐ Mental Health Disorder _____
- ☐ Multiple Sclerosis _____
- ☐ Muscular Dystrophy _____
- ☐ Orthopedic Impairment _____
- ☐ Spina Bifada _____
- ☐ Other: _____

_____

Have you been hospitalized during the past 5 years? ☐ YES ☐ NO
When and What For? _____

_____

_____

Do you receive any therapies (Occupational, Physical, Speech, etc…)? If yes, when/where:

_____

_____

Are you now receiving, or have you ever received, ***treatment / therapy / counseling*** for any mental health needs? If YES, why and how often? _____

_____

_____

Please list your medications: (Prescribed and Over-the-Counter)

Name	To treat:
_____	_____
_____	_____
_____	_____
_____	_____

History of Substance Abuse: ☐ YES ☐ NO Type: _____

Behavioral Concerns

Do you ever:			**Frequency/Remedies:**
Exhibit inappropriate behaviors?	☐ YES	☐ NO	
Threatens others?	☐ YES	☐ NO	
Attempt to agress towards others?	☐ YES	☐ NO	
Demonstrate self-injurious behaviors?	☐ YES	☐ NO	
Destroy property/objects?	☐ YES	☐ NO	
Exhibit inappropriate sexual behaviors?	☐ YES	☐ NO	
Compulsive/Repetitive behaviors?	☐ YES	☐ NO	
Steal?	☐ YES	☐ NO	
Run Away?	☐ YES	☐ NO	
Set fires?	☐ YES	☐ NO	

Additional Comments/Notes: _____

Have you ever been ***abused / exploited*** by others? If YES, explain how and when: _____

Have you ever had any ***police or court*** involvement? If YES, explain: _____

Describe how you interact with others. : _____

How do you respond to new situations? _____

Communication / Mobility

Are you able to ambulate without assistance? ☐ YES ☐ NO
If No, do you use adaptive equipment (AFOs, wheelchair, stander, Hoyer lift, etc.)? ☐ YES ☐ NO
Explain: _____

Are you able to communicate verbally? ☐ YES ☐ NO

If No, what method of communication do you use?
☐ Sign Language ☐ Email/texting
☐ Gestures / Facial Expression ☐ Assistive Technology:_____

Educational Information

Copy of IEP Requested: ☐ YES ☐NO
Name / Address of ***Current/Last*** school:_____

_____County:_____

Did you receive special education services at ***this*** school? ☐ YES; Type:_____ ☐NO

What type of accommodations do/did you receive:_____

_____

Do/Did you have an IEP / 504 Plan? ☐ YES; Type:_____ ☐NO

- Please explain type of services received (For example, Speech/OT/PT, 1:1, etc…)

_____
_____
_____

Is/was there a Behavior Management Program (BMP) in effect? ☐ YES ☐NO
If YES, where, why, and how long was it in effect? _____
_____
_____
_____

Which will you be receiving/have you received?: ☐ Certificate ☐ High School Diploma
When? _____

Employment History (paid/volunteer/non-training)

Current Employer (City, State; Phone): _____
_____
Job Title: _____Job Duties: _____

Prior Employer (City, State; Phone): _____
_____
Job Title: _____Job Duties: _____
Dates: _____

Prior Employer (City, State; Phone): _____
_____
Job Title: _____Job Duties: _____
Dates: _____

Functional Levels

(Use additional pages if necessary)

Personal Management

Skill:	Assistance Needed?:	Comments/examples:
Eating:		
• Uses utensils		
• Prone to choking		
• Table manners		
Personal Hygiene:		
• Bathroom		
• Bathing		
• Brushing teeth/hair		
• Shaving		
• Menstrual care		
• First aid		
• Communicating illness		
Dressing/Undressing		
Taking medications		
Care for personal possessions		

Are you self-medicating? ☐ YES ☐ NO _____

Additional comments/observations: _____

Household Management

Skill:	Assistance Needed?:	Comments/examples
Menu Planning & Food Prep		
• Measuring		
• ID labels		
• Using microwave		
• Uses Stove/Oven		
Grocery & clothes shopping		
• Prepares list		
• Knows to wait for change		
• Makes simple purchases		
• Able to compare prices		
Money skills		
• Understanding value		
• Budgeting		
• ID currency bills/coins		
• Able to make change		
• Basic banking skills		
Time Management		
• Able to tell time		
• Uses alarm clock		
• Ready on time		
• Follows schedule		
Care of Premises		
• Vacuum		
• Dust		
• Wash dishes		
• Laundry		
• Mow lawn		

Additional comments/observations:

Community Resources

Skill:	Assistance Needed?:	Comments/examples:
Phone		
• Make calls		
• Receive calls		
• Take messages		
• Find numbers		
• Identify phone number		
Emergency		
• Identify an emergency vs. non-emergency		
• 911 procedure		
• Identify address		
Safety		
• Respond to posted signs		
• Appropriate with strangers		
• Able to cross street		
Transportation		
• Drive		
• Use public transportation		
• Able to follow directions		
Use of Community Services		
• Complete applications		
• Access and use pharmacy		
• Schedule medical appointments		
Reading		
• Email		
• Internet		
Writing		
Use Technology		

Additional comments/observations:

Supervision Requirements

Can you be SAFELY left alone for any period of time? ☐ YES ☐NO ☐ No Opportunity

If YES, under what circumstance and for how long?_____

_____

_____

If NO or No Opportunity, please describe why:_____

_____

_____

_____

If left alone, would you know when & how to *(provide examples for each)*:

Contact 911? ☐ YES ☐NO Get help in an emergency? ☐ YES ☐NO

Do you recognize a dangerous situation & know what to do? ☐ YES ☐NO

Explain:_____

_____

_____

Priority Justification

Family Composition

Name/Relationship of primary caregiver:_____ Age:_____

Have you ever been appointed a Legal Guardian by the Courts / State? ☐ Yes ☐ No

If YES:
Guardian*: _____ _____ _____

Name DOB Address / Phone

(If applicable, type of guardianship: _____)

Copy of legal guardianship paperwork: ☐ OBTAINED ☐ REQUESTED

		How Long?
Is the primary caregiver able to continue caring for you?	☐Yes ☐ No	_____
Can you continue to live in the current situation?	☐Yes ☐ No	_____
Do you want to change living arrangements?	☐Yes ☐ No	_____

What do you presently do during the day? _____

_____

_____

Impact on Applicant's Family / Caregivers

How do your disabilities affect your parents/caregiver? _____

Describe any ***health issues*** which might inhibit caregiving? _____

Are there any household ***financial difficulties*** affecting your ability to pay for services? _____

Are there any ***special circumstances*** we should know about? _____

Who are your other natural supports / who can help you when you need help?

Name	Relationship	Location

What are your goals and what type assistance would help you to achieve these goals? _____

What are your parent's/guardian's goals for you and what type assistance would help you to achieve these goals? _____

Other Services, Benefits and Waivers

Do you receive any of the following benefits or have the following sources of income?

☐ WAGES ☐ HUD / RENTAL ASSISTANCE ☐ SSI ☐ FOOD STAMPS
☐ SSDI ☐ CHILD SUPPORT ☐ SSA ☐ TEMPORARY CASH ASSISTANCE
☐ VA ☐ ENERGY ASSISTANCE

Other Resources that may be useful:_____

_____

_____

_____

Do you participate in any other Waiver or Service (verify from DDA Application)? ☐ YES ☐ NO

☐ Autism Waiver ☐ Living at Home Waiver ☐ Medical Day Waiver
☐ Model Waiver ☐ TBI Waiver ☐ RTC Waiver
☐ REM ☐ DORS ☐ LISS
☐ Other: _____