



14423 W McDowell RD G104
Goodyear, AZ 85395
Office: 623 547-4839 and Fax: 623 547-4567
www.divinecare.org

(HCBS)MEMBER INFORMATION PACKET

Date _____

Consumer Name _____

Date of Birth ____/____/____ Gender: Male ____ Female: ____

Address _____

City, State, Zip-code _____

Phone Number (____) _____

Guardianship Status (please provide copies of supporting court documents)

Parent/Guardian _____

Mailing Address _____

City, State, Zip-code _____

Home Phone (____) _____ Cell or Work Phone (____) _____

Email Address _____@_____

Name and Address of School (if applicable)

Support Coordinator:	
Office:	
Address:	
Phone:	
Fax:	
Email:	

Emergency Contact Information

In case of an emergency and you are unable to be reached, who we should contact:

Name: _____ Relation _____

Address _____ Phone () _____

Name: _____ Relation _____

Address _____ Phone () _____

Member's Doctor's Name _____

Doctor's Phone _____

Hospital Preference _____

Hospital Address _____

Hospital Phone _____

Name of Health Plan/Medical Insurance _____

Group Number/ Policy Number _____

Primary Name on Insurance _____

Please list the name and relationship of any persons NOT authorized to pick up or interact with the consumer:

Name	Relation
_____	_____
_____	_____

General Agreements and Consents

I _____, certify that I am the
(Full name of the legally responsible person)
_____ of _____, who
Relationship to the individual full name of the individual
is supported by Divine Care LLC.

I consent to the following for member named above and supported by Divine Care for a period of time not to exceed 12 months from the date of the signature below.

(Check all that apply):

- Routine medical treatment.
- Emergency medical treatment.
- I request to receive a copy of Outcomes / Progress notes quarterly.
- Divine Care DOES NOT Administration over the counter medications with out physician's orders.
- Participation in routine recreational/leisure activities.
- Participation in planned and un-planned field trips.
- Release of medical records.
- Release of educational records.
- Release of psychological records.

Member's signature (if applicable)

Date

Responsible person's signature

Date

14423 W McDowell RD G104
Goodyear, AZ 85395

Signature

Date

Allergies

Does the member have any allergies? Yes ___ No ___ **If yes**, please list the substance the consumer is allergic to and describe the reaction: _____

Seizures

Does the member have seizures? Yes ___ No ___

How often do the seizures usually occur? _____

How long do the seizures usually last? _____

Does the member sleep after the seizure occurs? Yes ___ No ___

Please describe the type of seizures, any triggers to the seizures, and how you and the member normally respond before and during and after the seizure: _____

Special Considerations

Does the member take the medication for his/her blood pressure? Yes ___ No ___ If yes, what monitoring techniques are to be used and what procedures should be followed if the blood pressure is out of established ranges? _____

Does the member take medication for bowel movements? Yes ___ No ___ if yes, what type of monitoring is required? _____

Does the member have diabetes? Yes ___ No ___ If yes, what are the instructions for blood sugar monitoring?

Does the member take any thinning medications? Yes ___ No ___ If yes, please specify: _____

Does the member require any special lab work on a regular basis (Lithium, Dilantin, Thyroid levels, etc?) ? Yes ___ No ___ If yes please specify what is required and at what frequency:

List any medical restrictions to activities:

Please describe any special techniques for handling medical concerns:

Activities of Daily Living

Please briefly describe your typical daily routine:

Is there a need for adaptive equipment? Yes _____ No _____ If yes, please describe the type of equipment and when it should be used: _____

Is there a need for protective devices? Yes _____ No _____ if yes, please describe the type of equipment and when it should be used:

Please identify any special instructions for lifting, carrying, and positioning: _____

Please identify any gender preferences for personal care:

Male _____ Female _____ No preference _____

Personal Care

Please check only those that best apply to current activity of daily living needs.

TOILETING

PLEASE DESCRIBE:

- Uses the toilet independently
- Needs some assistance with toileting
- Needs reminders to use the toilet
- In diapers or Attends

BATHING

- Bathes independently
- Needs some assistance with bathing
- Needs reminders to bathe

HYGIENE (teeth brushing, hair brushing, hand wash, etc.)

- Completes hygiene routine independently
- Needs some assistance with hygiene
- Needs reminders to complete hygiene

DRESSING

- Dresses himself/herself independently
- Needs some assistance with dressing
- Needs reminders to dress

FEEDING

- Feeds himself/herself independently
- Needs some assistance with feeding
- Has a feeding tube
- Is on a special diet

Nutritional Needs

Please provide the consumers need for food preparation:

Regular Bite-sized Puree Other If other please describe:

Please indicate any special diet or nutritional supplements: _____

Are there any concerns regarding choking or gag reflex? Yes _____ No _____ If yes, please describe:

Fluid Needs

Can the obtain/request fluids? Yes _____ No _____ If no, please specify the fluid recommendations and how to ensure that adequate fluids are provided: _____

Communication

What languages are spoken? _____

What languages are understood? _____

Are there any communication deficits? Yes _____ No _____ If yes, please describe:

Please explain any words or sounds the consumer uses regularly that can help us to understand and communicate with that him/her: _____

Please describe any special communication techniques used (Sign language, visual chart, communication board, etc.): _____

Auditory, Tactile, and Visual Skills

Are there any auditory (hearing) issues? Yes _____ No _____ If yes, please describe:

Are there any tactile (touch) issues? Yes _____ No _____ If yes, please describe:

Are there any visual issues? Yes _____ No _____ If yes, please describe: _____

Motor Skills

Does the consumer have any limitations in physical functioning? Yes ____ No ____
If yes, please describe: _____

Supervision Needs

What is the length of time and the places that the member can safely be unsupervised (consider time in the bathroom, at any programs, in the consumer's own home/bedroom, etc.):

Please describe any possible risks (does he/she is he/she attracted to unsafe items or situations) if the person is unsupervised or missing: _____

Like / Dislikes

What activities does the consumer like to participate in? _____

What activities does the consumer not like to participate in? _____

Please list names of family members, friends, or pets that live at home or that the member frequently socializes with and or talks about.

Name

Relation in the member

_____	_____
_____	_____
_____	_____

What motivates the member? _____

What things does the member like? _____

What things does the member not like? _____

What triggers these behaviors? _____

What warning sign are there for these behaviors? _____

Is there a current behavior program and or discipline technique for the member?
Yes ____ No ____ If yes, please describe: _____

Parent / guardian suggestions: _____

Parent / guardian requests (please note, we will make every attempt to comply with your request within the boundaries of the law and current best known practices):

Signature of person completing the form

Relation to the member

Individual Information:

Individual's Name: _____ M or F: _____ Date of Birth: _____
 Name the individual prefers to be called: _____ Grade: _____

Primary Guardian's Information:

Primary Guardian's Name: _____ Cell Phone #: _____
 Physical Address: _____
 Mailing Address: _____
 E-mail Address: _____ Home #: _____
 Employer: _____ Employer Phone #: _____

Secondary Guardian's Information:

Secondary Guardian's Name: _____ Cell Phone #: _____
 Mailing Address: _____
 E-mail Address: _____ Home #: _____
 Employer: _____ Employer Phone #: _____

List persons who can either pick up and/or assume responsibility for your individual in the event of an emergency if parents cannot be reached. At least one non-guardian contact person must be listed with their phone number:

Non-Guardian Contact Name: _____ Cell Phone #: _____

Does your individual have any health concerns (medications, chronic conditions, behavioral or cognitive disabilities) that we should know about in order to facilitate safe and successful participation? Yes or No

If yes, please describe: _____

Known allergies and reactions: _____

Medications and frequency of use: _____

Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Please give any additional information concerning your child, which may be helpful: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE:

I hereby give permission to the Divine Care staff to secure emergency medical and/or surgical treatment for my individual while in their care. All expenses of such care will be accepted by the parent(s)/legal guardian, including fees for an ambulance, if deemed necessary by staff. I realize attempts to reach me prior to any decisions will be made unless a life-threatening situation is at hand or circumstances do not allow.

Signed: _____ Date: _____
 Parent or Legal Guardian