



Helping People Help Themselves

Carol Manne
President & CEO

40 Mechanic Street, Suite #100
Marlborough, MA 01752

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:	
DOB:	SS#:
Address:	
Phone: ()	Cell: ()

I, _____, authorize Greater Marlboro Programs, Inc.(GMPI) and/or Department of Developmental Services (DDS) to secure the information noted on the following pages.

I understand that this information is confidential and will be held by **Greater Marlboro Programs, Inc.**

I give my consent voluntarily, free from duress and without threat of punishment of special promise.

Signature of Applicant or Guardian

Date

(Please send this information to the address on this letterhead.
This information is to be used for the purpose of coordinating, managing and determining financial eligibility for services and supports through GMPI.)

*Dedicated to promoting the personal growth, dignity and acceptance
of people with developmental disabilities*



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Dear Family Support Recipient/Parent/Guardian,

Enclosed please find the new updated Intake Packet. Please complete these forms and return to GMPI along with a recent photograph and a copy of your ISP/IEP. Your response ensures that the services you receive continue to meet your individual needs.

These forms must **be fully completed and returned** to GMPI as soon as possible. A pre-addressed envelope is enclosed for your convenience.

If there has been any major changes in your life, for example; behavioral, medical, medication changes, or any other information that would be pertinent, please list these changes on the ***Emergency Fact Sheet***.

We will do our utmost to meet the needs of your family during this difficult transition and look forward to working with you in the future.

Sincerely,

Sharon Santello
Director of Family
& Individual Support
(508) 485-4227 X104

Denise Vojackova-Karami
Vice President of Developmental
Services
(508) 485-4227 X 102

Carol Manne
President & CEO

(508) 485-4227 X101

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EMERGENCY FACT SHEET

<u>CLIENT NAME:</u>		<u>NICKNAME:</u>		<u>ATTACH PICTURE HERE</u>
<u>CURRENT ADDRESS:</u>				
<u>FORMER ADDRESS:</u>				
<u>SEX:</u>	<u>RACE:</u>	<u>BIRTHDATE:</u>	<u>AGE:</u>	
<u>HEIGHT:</u>	<u>WEIGHT:</u>	<u>BUILD:</u>	<u>HAIR:</u> <u>EYES:</u>	
<u>DISTINGUISHING MARKS:</u>				
<u>LEGAL COMPETENCY STATUS:</u>				
<u>IF LEGAL GUARDIAN, NAME:</u>			<u>PHONE:</u>	
<u>ADDRESS:</u>				
<u>FAMILY ADDRESS (if different):</u>			<u>PHONE:</u>	
<u>TRAINING PROGRAM/SCHOOL ADDRESS:</u>			<u>PHONE:</u>	
<u>WORK ADDRESS:</u>			<u>PHONE:</u>	
<u>RELEVANT EMERGENCY MEDICAL INFORMATION: (ALLERGIES, MEDICATION NEEDS, ETC.):</u>				
<u>PHYSICIAN'S NAME:</u>		<u>ADDRESS:</u>	<u>PHONE:</u>	
<u>LANGUAGE/COMMUNICATION:</u>		<u>ABILITY TO PROTECT SELF WITHOUT ASSISTANCE:</u>		
<u>SIGNIFICANT BEHAVIOR CHARACTERISTICS:</u>		<u>LIKELY RESPONSE TO SEARCH EFFORTS:</u>		
<u>PATTERN OF MOVEMENT IF LOST PREVIOUSLY:</u>		<u>PLACES FREQUENTED:</u>		
<u>RELEVANT CAPABILITIES, LIMITATIONS, AND PREFERENCES:</u>				
<u>PROBABLE DRESS:</u>				
<u>WHERE AND WHEN THE INDIVIDUAL WAS LAST SEEN:</u>		<u>DATE:</u>	<u>TIME:</u>	
<u>CONTACT PERSON(S):</u>			<u>PHONE:</u>	
<u>CLIENT NAME:</u>		<u>AREA:</u>		
<u>RECORD LOCATION:</u>		DATE:		

ACTIVITIES OF DAILY LIVING

Eating:

_____ eats and drinks independently _____ requires assistance
_____ needs to be fed
_____ preferences
_____ special diet _____
_____ adaptive equipment _____
_____ behavioral concerns _____

Comments: _____

Bathing:

_____ bathes independently _____ requires assistance _____ totally dependent
_____ prefers bath _____ prefers shower
_____ brushes teeth independently _____ need assistance
_____ shaving needs _____
_____ dressing needs _____
_____ adaptive equipment _____

Comments: _____

Toileting:

_____ independent _____
_____ needs assistance/supervision _____
_____ totally dependent _____
_____ menstruation (special needs) _____
_____ night time needs _____

Toileting (continued):

_____diapers/disposable undergarments_____

_____training program_____

_____behavioral concerns_____

Comments:_____

Sleeping:

_____sleeps through the night_____

_____wakes during the night_____

usual bedtime _____ usual wake time _____ weekends _____

bedtime routine _____

comments: _____

Physical Abilities:

Vision: ___full sight ___normal with glasses ___impaired ___blind

Hearing: ___full hearing ___normal with aids ___impaired ___deaf

Communication:

What language does the individual understand? _____

___ communicates effectively _____ speech difficult to understand

___ sign language _____ communication program _____ gestural
(ASL,adaptive, etc.)

___ non-verbal, communicates by _____

Comments:_____

Skills:

Needs help with ambulation? If so please explain what type of assistance is required:

Requires any assistance with eating? If so please explain what type of assistance is required:

Any special food preparations or considerations? If so please explain: _____

Knows how to swim? _____

Communication:

Communication skills: _____

Ways of expressing needs: _____

Can communicate to someone that he/she is sick. _____

Social Skills:

Can stay at home alone? _____

Can use a telephone or a pay phone? _____

Can tell time? _____

Needs assistance managing own money? _____

What type of supervision is required in the community? (constant, moderate, minimal)

Please specify and explain:

BEHAVIOR:

Are there any outstanding behavioral problems and/or emotional illnesses?

How should escalating behaviors be redirected?

How well are changes in routine handled?

Any issues or concerns when riding in a vehicle?:

How well is the behavior in the community?_

Respite Care:

Respite provider preference:

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> In home | <input type="checkbox"/> Out of home |
| <input type="checkbox"/> Day | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Weekends | <input type="checkbox"/> Overnights |
| <input type="checkbox"/> Male | <input type="checkbox"/> Female |

Respite Care (Cont.)

Age Preference: _____

Smoking: ___ Yes ___ No

Pets: ___ Yes ___ No

Children ___ Yes ___ No

Group Actv. ___ Yes ___ No

Comments:

Person providing information: _____ Phone: _____

Relationship to individual: _____

Referral source: _____ Phone: _____

Service Coordinator: _____ Phone: _____

Completed by: _____
