|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NAME: | Click here to enter text. | | | | | | | DATE: | | Click here to enter a date. | | | | DDD ID# | | | | | Click here to enter text. | |
| Residential Agency: | | | | Click here to enter text. | | | | Residential Address: | | | | | | Click here to enter text. | | | | | | |
| Residential Contact Person: | | | | Click here to enter text. | | | | Residential Phone: | | | | | | Click here to enter text. | | | | | | |
| Agency Behaviorist: | | | | Click here to enter text. | | | | Behaviorist Phone: | | | | | | Click here to enter text. | | | | | | |
| Day Program Agency: | | | | Click here to enter text. | | | | Day Program Address: | | | | | | Click here to enter text. | | | | | | |
| Day Prog. Contact Person: | | | | Click here to enter text. | | | | Day Program Phone: | | | | | | Click here to enter text. | | | | | | |
| Are other intervention organizations involved? Cares NSTM DDHA | | | | | | | | | | | | | | | | | | | | |
| PPM Date: | | | | | Click here to enter a date. | | | | Projected Move Date: | | | | | | | Click here to enter a date. | | | | |
| Level of Intellectual Disability:  Profound  Severe  Moderate  Mild  Borderline | | | | | | | | | | | | | | | | | | | | |
| Ambulation Status:  Ambulatory  Non-Ambulatory  Ambulates with assistance | | | | | | | | | | | | | | | | | | | | |
| Please complete for the behaviors of highest concern. | | | | | | | | | | | | | | | | | | | | |
| Behavior Label: | | | | Click here to enter text. | | | | | | | | | | | | | | | | |
| Frequency: | | Click here to enter text. | | Description: | | | Click here to enter text. | | | | | | | | | | Severity: | | | Mild  Moderate  Severe |
| Behavior Label: | | | | Click here to enter text. | | | | | | | | | | | | | | | | |
| Frequency: | | Click here to enter text. | | Description: | | | Click here to enter text. | | | | | | | | | | Severity: | | | Mild  Moderate  Severe |
| Behavior Label: | | | | Click here to enter text. | | | | | | | | | | | | | | | | |
| Frequency: | | Click here to enter text. | | Description: | | | Click here to enter text. | | | | | | | | | | Severity: | | | Mild  Moderate  Severe |
| Psychiatric Diagnosis: (If none state NA) | | | Click here to enter text. | | | | | | | | | | | | | | | | | |
| Is client currently on psychotropic medications: | | | | | | | | | | | | | | | Yes | | | | | No |
| **The below documents should be submitted with referral if available:** | | | | | | | | | | | | | | | | | | | | |
| Current Service Plan (IHP, ISP) | | | | | | Functional Behavior Assessment | | | | | | Behavioral Support Plan | | | | | | | | |
| Current Psychological Evaluation | | | | | | Current Psychiatric Evaluation (If one has been completed) | | | | | | Health Safety Risk Summary | | | | | | | | |
| Staff Member Completing Form: | | | | Click here to enter text. | | | | | | | Title: | | Click here to enter text. | | | | | | | |
| Contact Person (CM, TCM, SC): | | | | Click here to enter text. | | | | | | | Phone Number: | | | | | | | Click here to enter text. | | |
| Guardian: | | | | Click here to enter text. | | | | | | | Phone Number: | | | | | | | Click here to enter text. | | |

**To Be Completed by the Resource Team**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Form Reviewed: Click here to enter a date. | | | |
| Date Assigned: | Click here to enter a date. | Responsible Staff Person: | Click here to enter text. |