

Pre-Service Provider Orientation

Last Date Updated/Reviewed: _____ Reviewer: _____

Instructions: This form is to be completed by the Direct Support Professional and the individual and/or responsible party receiving services prior to the initiation of services and the form must be updated when there are changes to the member’s care needs or agreed-upon tasks. A copy *must* be retained by the Qualified Vendor and a copy sent to the Support Coordinator to save to the Member’s File.

Purpose

Individual’s Name (*Last, First, M.I.*): _____

Assists No.: _____ Birthdate: _____

Gender/Identity: _____ Language Preference: _____

Cultural Preference(s): _____

Qualifying Diagnosis: _____ Other Diagnosis(s): _____

Individual’s Address (*No., Street, City, State, ZIP Code*):

Electronic Visit Verification (EVV) Device Preference Use: _____

Does the Member have an Advanced Directive: Yes No

Does the Member Smoke: Yes No

Does the Member Drink Alcoholic Beverages: Yes No

Specialized Training

Medication Administration Training Needed: Yes No

Seizure Management Training Needed: Yes No

Feeding Training Needed: Yes No

Prevention & Support Training Needed: Yes No

Behavior Plan Training Needed: Yes No

Mobility/Transferring Training Needed: Yes No

Mobility Training Needed: Yes No

Is there any additional specialized training required? Yes No

If yes, Describe: _____

Guardian/Responsible Person Information

Guardian's/Responsible Person's Name (*Last, First, M.I.*): _____

Relationship: _____ Phone Number: _____

Language Preference: _____ Email Address: _____

Cultural Preference(s): _____

Address (*No., Street, City, State, ZIP Code*): _____

Emergency Contact's Name (*If other than responsible party*): _____

Relationship: _____ Phone Number: _____

Medical/Behavior Health Contact Information

Name of ALTCS/DDD Health Plan: _____

AHCCCS ID No.: _____ Phone Number _____

Other Health Insurance Information: _____

Primary Care Physician's Name: _____ Phone Number _____

Address (*No., Street, City, State, ZIP Code*): _____

Pharmacy: _____ Pharmacy Number: _____

Address (*No., Street, City, State, ZIP Code*): _____

Behavioral Health Provider: _____ Behavior Health Phone: _____

Urgent Care Facility's Name: _____ Phone Number: _____

Address (*No., Street, City, State, ZIP Code*): _____

Support Coordination Contact Information

Support Coordinator's Name: _____

Office Location: _____ Phone Number: _____

Support Coordinator Supervisor: _____

Support Coordinator Supervisor Phone: _____

Support Coordinator Supervisor Email: _____

Health-Medical

Current Medications and Support Needs:

Medication Log Required: Yes No

Medication via the Gastrointestinal (GI) Tract: Yes No

Where can a list of current medications and any special instructions be found?

Allergies To:

Food: Yes No Specify: _____

Medication: Yes No Specify: _____

Bee Stings: Yes No Specify: _____

Other: Yes No Specify: _____

Required Response to Allergic Reaction, provide any written orders for Health Care Professional:

Seizures:

Yes No If yes, describe what type of seizure and what they look like:

Frequency: _____ Approximate Duration: _____

Required Response to Seizure Activity: Provide any written orders from the Health Care Professional:

Nursing Services Required: Yes No

Assistive Devices: Yes No

Vision: _____ Hearing: _____ Dental Appliances: _____

Other Individualized Health Care Routines:

Member's Needs						
Eating (Check All Applicable Items)						
	Utensils	Food Prep	Bringing Food to Mouth	Choking	Understands Temperature of Food	Other
Independent, no support required						
Prompting/Reminding Required						
Limited Assistance/Supervision Required						
Significant Assistance/Supervision Required						

Describe Any Special Dietary Requirements Including Food Consistency, Temperature, Calorie Needs or Write NA:

Tasks Responsible Person will Complete	Tasks Provider will Complete

Drinking (Check All Applicable Items)						
	Ability to Use Cup or Glass	Ability to Use Adaptive Cup or Glass	Able to Obtain or Request Beverages	Understands Temperature of Beverages	Choking	Other (Describe Below)
Independent, no support required						
Prompting/Reminding Required						
Limited Assistance/Supervision Required						
Significant Assistance/Supervision Required						

Describe Any Adaptive Drinking Equipment/Special Liquid Intake Needs/System for Fluid Intake or Write NA:

Tasks Responsible Person will Complete	Tasks Provider will Complete

Special Diet

Intake of Food via the Gastrointestinal (GI) Tract: Yes No

(Special instructions required / check type and include special instructions)

Nasogastric Tube (NGT) _____

Orogastric Tube (OGT) _____

Nasoenteric Tube _____

Oroenteric Tube _____

Gastrostomy Tube _____

Jejunostomy Tube _____

Who will provide training by when? _____

Eating Disorder *(Describe type and support needed)*: Yes No

Other Dietary Restrictions *(Describe)*: Yes No

Tasks Responsible Person will Complete	Tasks Provider will Complete

Communication <i>(Check All Applicable Items)</i>						
	Uses Complex Sentences	Uses Simple Sentences	American Sign Language	Nods Yes/No	Gestures/ Signs	Other (Describe Below)
Independent, no support required						
Prompting/ Reminding Required						
Limited Assistance/ Supervision Required						
Significant Assistance/ Supervision Required						

Describe Any Other Communication Requirements or Write NA:

Describe Augmentative Communication Device or Write NA:

Mobility (Check All Applicable Items)							
	Crawling/ Scooting	Kneeling	Standing	Walking	Running	Climbing	Other (Describe Below)
Independent, no support required							
Prompting/ Reminding Required							
Limited Assistance/ Supervision Required							
Maximum Assistance/ Supervision Required							

Describe Any Other Mobility Requirements or Write NA:

For any devices, who will provide the training and by when? _____

Mobility/Balance Aids (Check as applicable)

N/A Walker Cane Crutches AFOs Leg Braces Manual Wheelchair

Power Wheelchair Other (Specify): _____

Transfer Support Needed: Yes No If yes, height: _____ Weight: _____

One-Person Lift Two-Person Lift Mechanical Lift Lift/Transfer Less than 50 lbs

Lift/Transfer More than 50 lbs Slide Board

Lifting/Carrying Instructions: _____

Positioning Instructions: _____

Transportation Support Needed:

Car Seat Adaptive Vehicle Required Other Transportation Needs _____

Tasks Responsible Person will Complete	Tasks Provider will Complete

Personal Care (Check All Applicable Items)							
	Dressing	Toileting	Bathing	Oral Hygiene	Menses (if applicable)	Med. Admin	Other (Describe Below)
Independent, no support required							
Prompting/Reminding Required							
Limited Assistance/ Supervision Required							
Maximum Assistance/ Supervision Required							

Describe Special Personal Care Needs and Preferences or Write NA:

Tasks Responsible Person will Complete	Tasks Provider will Complete

Behavior (If applicable)		Yes	No
Brief Description	Approximate Frequency	Recommended Intervention	
Verbal Aggression			
Physical Aggression			
Self-Injurious Behavior			
Property Destruction			
Member Leaves Area w/o Informing Anyone			
Self-Stimulation			
Sexual Acting Out			
Crisis Intervention/ Hospitalization within last 6 months			

Behavior (If applicable)		Yes	No
Brief Description	Approximate Frequency	Recommended Intervention	
Extreme Liquid/Food Seeking			
Ingesting Non-Edible Objects			
Difficulty with Transitions			
Difficulty Understanding consequences			
Substance Abuse – Drug, Alcohol, Other			
Other			

Is a Behavior Treatment Plan (BTP) Available for Additional Information Yes No

Reason for BTP _____

Method Used to Obtain Information (e.g., in person, case file) _____

Is there a Functional Behavior Assessment (FBA) Available for Additional Information: Yes No

Is there a Crisis Intervention Plan Available for Additional Information: Yes No

Is there additional Behavior Health Support provided through the Health Plan: Yes No

Where is the additional information saved (e.g., in person, case file): _____

Protective Devices: Yes No

Prescription on File: Yes No PRC Approval Date: _____

Instructions for Use: _____

Purpose: _____

Tasks Responsible Person will Complete	Tasks Provider will Complete

Employment/Day Program (If applicable)

Name of Employment Day Program: _____

Program Type: _____

Days and Hours of Attendance: _____

Transportation Method: _____

Day Program Address (No., Street, City, State, ZIP Code): _____

Phone Number: _____ Are there any special staffing needs: _____

Provider Information

Provider's Name (*Last, First, M.I.*): _____

Qualified Vendor: _____

Qualified Vendor Address: _____

Emergency Contact: _____ After Hours Phone Number: _____

Signatures

Signature of Person Completing if Not Responsible Party: _____

Relationship: _____ Date: _____

Print Provider's Name: _____

Provider's Signature: _____ Date: _____

Print Responsible Person's/Guardian's Name: _____

Responsible Person's/Guardian's Signature: _____ Date: _____

Distribution: Copy – Provider; Copy – District Office; Copy – Parent/Guardian; Copy – Support Coordinator