ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PRE-SERVICE PROVIDER ORIENTATION

Last Date Updated/Reviewed: _____ Reviewer: _____

INSTRUCTIONS: This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services and updated annually thereafter. A copy MUST be retained by the provider and a copy sent to the Support Coordinator to save to the Member's File.

MEMBER INFORMATION

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)*: _____

See page 6 for EOE/ADA disclosures

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

Where can a list of current medication 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 for Health Care Professional:

_____

Nursing Services Required: ☐ Yes ☐ No

ASSISTIVE DEVICES: ☐ Yes ☐ No

Vision: _____ Hearing: _____ Dental Appliances: _____

Other Individualized Health Care Routines:

NUTRITION

EATING *(CHECK ALL APPLICABLE ITEMS)*							
	Utensils	**Food Prep**	**Bringing Food to Mouth**	**Choking**	**Menses**	**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:

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:

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 _____

COMMUNICATION *(CHECK ALL APPLICABLE ITEMS)*						
	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 _____

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:

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		
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: _____

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