Title: Emergency Temporary Living Arrangements Policy

Approved By: [Signature]

Division Director

Written/Revised By: ____________________________ Date of Origin: January 1987

Date of Current Review/Revision: September 2008

I. PURPOSE

To establish guidelines for the provision of emergency temporary living arrangements (ETLA) for individuals eligible to receive DDDS services when their current living arrangement is abruptly terminated. The individual may be receiving family support services or already be in a community residential setting.

II. POLICY

It shall be the policy of the Division to provide emergency living arrangements in the most appropriate and least restrictive environment available to the individual at the time of need.

III. APPLICATION

DDDS Staff and all contractors with the DDDS

IV. DEFINITIONS

A. Authorized Provider: An agency or Shared Living Provider that is fully authorized/approved to provide residential services for the Division.

B. Change of Status Form – Notification of any informational (status) change that occurs regarding a DDDS eligible individual, (e.g., demographics, financial, programmatic). Change of Status Form(s) shall be submitted to Health Information Management (H.I.M.) within one business of the status change occurring.

C. Emergency Temporary Living Arrangement (ETLA): A short-term residential placement for individuals who have been displaced.

D. Essential Lifestyle Plan (ELP) – A person centered plan developed with the person receiving services, his/her family or guardian, and other individuals providing support that outlines in detail the individual’s preferences, support needs, and lifestyle choices.

E. Individual Profile: A document that details an individual’s personal information, insurance information, support needs, and emergency contact information.

F. Inventory for Client and Agency Planning (ICAP): An Assessment tool used by DDDS to determine an individual’s support needs and associated funding.
G. Office of Budget, Contracts, and Business Services (OBCBS) – The Division’s department responsible for managing the Division’s budget and developing/managing contracts with residential and/or day service providers.

H. Managers Placement Alert Email: An email sent by ORDM to all regional managers/supervisors alerting them of a placement and contract effective date.

I. Office of Resource Development and Management (ORDM) – The Division’s department responsible for developing and managing the Division’s residential placement resources/options.

J. Inventory for Client and Agency Planning (ICAP) Initial Request Packet: The documents the Family Support Specialist or Case Manager submits requesting an ICAP be completed.

K. Provider Notebook: A Notebook developed by the ORDM, Shared Living/Respite Unit and the DDDS team which contains general information such as information about the DDDS on-call system and general medical information. Specific information pertaining to the individual who is moving will be filed in the notebook by the DDDS team. A notebook is given to all Shared Living Providers who are doing an ETLA placement.

L. Regional Management Team: Consists of the Regional Program Director (RPD); Nurse Supervisor; Behavior Analyst Supervisor; Case Manager Supervisor; and the Family Support Specialist Supervisor.

M. Residential/Vocational Rate Referral Request: A form submitted along with the current ICAP Summary to the Office of Budget, Contracts, and Business Services to obtain an individual’s ICAP funding rate.

N. Support – A broad term used to refer to those methods designed to help an individual achieve a meaningful life and to function to his/her fullest capacity.

V. STANDARDS

A. Emergency Temporary Living Arrangements shall be provided for the following, but only after alternative supports/options have been explored:
   • individuals served by the Family Support unit who require immediate, emergency residential placement due to being homeless or at risk for abuse or neglect
   • individuals residing in a community residential setting who must move immediately due to the termination of their provider’s contract, a PM-46 investigation with an administrative decision to move the individual, or the inability of the current provider to render supports due to an unanticipated family matter such as the caregiver’s hospitalization, death, or family emergency.
   • individuals who have been removed from their home by Adult Protective Services (APS) and who are currently on the DDDS Registry or who have been appropriately screened & appear to meet the criteria to be eligible for DDDS Services
   • individuals who have been removed from their home by the Department of Children, Youth, and their Families (DFS) who are currently on the DDDS Registry or who have been appropriately screened & appear to meet the criteria to be eligible for DDDS Services.

B. The ETLA placement efforts shall be made in such a way to maintain the individual’s lifestyle in as similar type of environment as is reasonably possible given current availability. Efforts shall be made to find the best possible ETLA in the individual’s current county so he/she may continue at his/her current
day program or school. The living arrangement shall be with an approved provider (shared living or agency), unless the situation dictates the use of a non-approved provider.

C. The Family Support Specialist, Case Manager and other ID team members, or APS/DFS case worker shall ensure that the individual arrives to the ETLA placement with his/her needed belongings, medications, and medical cards. Any other needed items specific to that individual shall also be supplied at that time.

D. Payment shall be determined by calculating the individual’s ICAP rate and adding that amount, if any, to the standard Room & Board. In the event that an ICAP has not yet been completed, the payment shall be the standard Room & Board rate with adjusted supplemental payment for difficulty of care, as approved by the Director of Residential Development/Designee.

E. If no ICAP has been completed, the Family Support Specialist shall request one by completing an ICAP Initial Request Packet within 2 business days of the ETLA placement. The ICAP Initial Request Packet will be submitted to the Family Support Supervisor who will then forward it to the Director of Residential Development with all required attachments.

F. If the individual is coming in from Family Support, the family shall be responsible for forwarding the individual’s awarded benefit monies to the Shared Living & Respite Supervisor within 5 business days and thereafter until such time the individual returns home or the representative payee status is awarded to the DDDS. At the time of the move, the Family Support Specialist shall provide the family with the Agreement to Forward Benefit Check(s) advising the family of this requirement. The family will be required to sign the agreement.

G. For individuals already on the Division’s Registry, a Change of Status Form shall be completed and forwarded to Health Information Management within one business day of the status change occurring. For those individuals not on the Division’s Registry, the Regional Family Support Supervisor or Director of Family Support shall notify the Regional Program Director (of the county in which the placement is going to occur), Regional Discipline Supervisors and Regional Administrative Support Specialist, who maintains the on-call information.

H. The assigned Family Support Specialist or Case Manager shall ensure that the provider receives written personal information about the person, on the day of the move. A Provider Notebook shall be provided within 2 business days of the move. Individuals who are already residing in a shared living placement will already have a provider notebook that can be updated by the DDDS team members and forwarded to the new provider. For those individuals who do not already have a provider notebook, the notebook shall be obtained from the regional Shared Living/Respite Office and then individualized by the Family Support Specialist, Case Manager, and/or other DDDS team members.

I. If individual is coming from Family Support or APS/DFS, additional ID team members shall be assigned within 2 business days and they shall complete assessments to determine if the person is in need of immediate medical/psychiatric/behavioral intervention. The team shall respond accordingly with ongoing necessary support/services.

J. The assigned team shall meet within 30 days or less to conduct a 30 Day Annual Conference and to continue to develop and/or update the ELP. The ELP should address the individual’s support needs and
provide adequate instruction to the ETLA Provider. The Team shall also discuss permanency planning or plans to return the individual to his/her residence of origin.

K. From the time the individual begins the ETLA placement, documentation shall be maintained as if the placement is a permanent admission.

L. Individuals admitted to ETLA shall be assessed for unsupervised time within two (2) business days of his/her move. Individuals shall not be unsupervised until the assessment is completed.

M. The DDDS team members and the Office of Resource Development and Management shall work towards a permanent residential solution within a maximum of 60 days of admission to the ETLA placement.

VI. PROCEDURES

ETLA Needed from Current Residential Placement
1. **Team member** aware of ETLa need notifies other team members, Case Manager Supervisor (CM Sup) and Regional Program Director (RPD) to discuss alternative supports/options and/or need for referral to Office of Resource Development and

2. **RPD or Designee** notifies the ORDM Shared Living & Respite Supervisor (SL&R Sup.) and Regional Shared Living Coordinator (SLC) of referral.

3. **Case Manager (CM) & Team** immediately reviews most current ELP, updates as needed, CM signs and dates ELP to indicate it has been reviewed and forwards ELP, ICAP Summary and Planned/Emergency Residential Placement Request to ORDM Regional SLC.

4. ORDM immediately reviews referral and contacts available agency and/or shared living providers (SLP) to determine ability to provide ETLa. **ORDM** discusses rate with agency provider or SLP.

5. Regional SLC contacts CM Sup to notify of 2-3 confirmed ETLa options.

6. **CM Sup** notifies team of the confirmed options. The team immediately reviews and determines which option will best meet ETLa needs and notifies CM Sup.
7. **CM Sup** notifies Regional SLC, RPD, BA Supervisor, and Nurse Supervisor of selected ETLa option.

8. **Regional SLC** notifies the chosen provider

9. **ORDM** determines rate, completes ETLa contract and sends Managers Placement Alert email.

10. **CM & team** arrange any services including transportation to the home and notifying individual, day service and family/guardian.

11. **Team** moves individual with provider notebook or COR and reviews with Provider.

12. **Transferring CM** completes and submits a Change of Status (COS) to Health Information Management.

13. **Transferring CM** schedules 30 Day Annual ELP or ELP Review within 30 days of ETLa start date. Until 30 Day ELP or ELP Review is held, at least one DDDS team member (CM, BA, RN) shall have **weekly** contact (phone, day program visit, and/or home visits) with individual.

**7a.** If individual is moving to another county, the Transferring RPD will notify the Receiving RPD.

- ETLA Contract
- Managers Placement Alert email
- Provider Notebook for SLP
- COR for Agency
- ID Note

**COS**

- ELP or ELP Review
- Annual Conf. Summary
14. Within 5 business days, Regional SLC contacts CM Sup to determine if placement is meeting temporary living needs.

15a. If not meeting temporary living needs, ORDM will identify other ETLA placement options.

15b. If meeting temporary living needs, ORDM will complete necessary paperwork in order to remove the individual from ETLA status.

16. Repeat process starting at step # 4

16. ORDM SL & R Sup sends Managers Placement Alert email.

17. RPD or Designee notifies team of contract effective date.

18. On the contract effective date, Transferring CM completes and submits a COS to HIM and assures completion of change of address with post office, financial institutions, credit card companies and 911.

19. If individual wants to explore other residential options, the team refers to Planned Placement Policy.
ETLA Needed- from Family Support/Referral

1. Family Support Specialist (FSS) notifies Family Support Supervisor (FS Sup) and/or Family Support Director (FS Dir) to discuss alternative supports/options and/or need for referral to Office of Resource Development Management (ORDM).

2. The FSS shall give a copy of the Comprehensive Medical (MAP 25) and Agreement to Forward Benefits Check(s) to the individual/family or guardian and ensure the following is signed and submitted by them before the referral is made to ORDM:
   1. Agreement for Participation in HCB Services
   3. Awareness Form Title XIX.
   4. Financial Responsibility Agreement
   5. Past three months of bank statements and pay stubs and any other financial information (i.e. trust, life insurance, burial information, etc.)

   - If Community resources are unavailable or there is an extended wait time for the MAP 25, the FSS informs FS Dir or Designee to contact the DDDS Medical Director to arrange for completion of the MAP 25.
   - FSS shall complete the entire waiver packet within ten business days and forward to FS Sup.
   - FS Sup reviews waiver packet for completeness, initials, and maintains packet.

3. FS Dir or Designee notifies the ORDM Shared Living & Respite Supervisor (SL&R Sup.) and Regional Shared Living Coordinator (SLC) of referral.
4. FSS reviews most current ELP/Individual Profile (IP), updates as needed, signs and dates to indicate it has been reviewed and forwards ELP/IP, ICAP Summary and Planned/Emergency Residential Placement Request to the ORDM Regional SLC. *If no ICAP, FSS completes ICAP Initial Request Packet to request completion of ICAP assessment within two business days of placement.

5. ORDM immediately reviews referral and contacts available agency and/or shared living providers (SLP) to determine ability to provide ETLA. ORDM discusses rate with agency provider or SLP.

6. Regional SLC contacts FS Sup to notify of 2-3 confirmed ETLA options.

7. FS Sup notifies FSS of the confirmed options. The FSS immediately reviews and determines which option will best meet ETLA needs and notifies FS Sup.

8. FS Sup notifies Regional SLC of choice.

9. Regional SLC notifies the chosen provider

10. ORDM determines rate, completes ETLA contract and sends Managers Placement Alert email.

11. FSS arranges all services including, transportation to home & notifying individual, day service provider and family/guardian. If individual does not have day/work program, FSS will make arrangements to obtain service.

12. FSS moves individual with ELP/IP and reviews with the Provider. A Provider Notebook shall be provided within two business days. FS Sup submits via email the ETLA information (individual’s name, SS#, DOB, emergency contact, provider’s name, and address) to the RPD, Regional Discipline Supervisors, and Regional Administrative Support Specialist of the county in which the placement is going to occur.
13. FSS completes and submits a Change of Status Form (COS) to Health Information Management (H.I.M.). FSS updates the individual’s Crisis Indicator to reflect the individual is in the emergency category of the DDDS registry.

14. Supervisors assign residential team. Within two business days, the team will complete assessments and file in Family Support chart and respond accordingly with ongoing necessary supports/services. FSS in conjunction with the residential CM, BA, & RN completes the Unsupervised Time Assessment.

15. FSS schedules ELP meeting within 30 days of ETIA start date. Until the ELP Meeting is held, at least one DDDS team member (FSS, CM, BA, RN) shall have weekly contact (phone, day program visits and/or home visit) with individual and/or provider.

16. Within five business days, the Regional SLC contacts FS Sup to determine if placement is meeting the temporary living needs.

17a. If not meeting the temporary living needs, ORDM will identify other ETIA placement options.

17b. If meeting temporary living needs, FS Sup forwards waiver packet to Regional SLC.

18. Repeat process starting at step # 5

18. ORDM will complete necessary paperwork in order to remove the individual from ETIA status

- COS
- Crisis Indicator
- BA Psychological Intake
- Intake Nursing ELP
- Nursing Fall Risk Assessment Tool
- Unsupervised Time

- ELP & Annual Conference Summary
- Waiver Packet
- Agency: Rate Request, ICAP Summary, & Waiver Packet
- Shared Living: Rate Request, ICAP Summary, Contract & Waiver Packet
VII. SYNOPSIS
This policy establishes clear processes for emergency transitions into or within the Community Services residential program when an existing living arrangement is abruptly terminated. The procedural flowchart delineates the required actions steps of all involved staff as well as the applicable required paperwork.

VIII. REFERENCES
Division of Developmental Disabilities Services & Division of Services for Aging and Adults with Physical Disabilities Memorandum of Understanding
Division of Child Mental Health Services, Division of Family Services, and Division of Developmental Disabilities Services Memorandum of Understanding

IX. EXHIBITS
A. Flow Chart Shapes Defined
B. Psychological Intake
C. Intake Nursing EL&P
D. DDDS Fall Risk Assessment Tool
E. Agreement to Forward Benefit Check(s) Monies
Exhibits (cont)

F. Planned and Emergency Residential Placement Request
G. Intake Nursing ELP
H. Individual Profile
I. ICAP Initial Request Packet
Flowchart Shapes Defined

- **PROCESS STEP**
- **DOCUMENT**
- **BEGINNING OR END PROCESS**
- **MULTI-DOCUMENT**
- **DECISION DIAMOND**
- **ALTERNATIVE PROCESS STEP**
EXHIBIT B

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
PSYCHOLOGICAL INTAKE

Name: ____________________________

MCI #: ____________________________

DOB: ____________________________

Is there a psychiatric diagnosis? _____________________________________________

What are the symptoms of the diagnosis? ______________________________________

Who is the current psychiatrist? _____________________________________________

What psychotropic medications (and doses) are currently prescribed? _____________

Are there any behavioral concerns? ____________________________________________

What are the precursors/triggers to the behaviors? _______________________________

Are there any inappropriate sexual behaviors? _________________________________

List all other current medications and reasons for taking? ________________________
Any important historical information:

Are there any past psychiatric diagnoses?

What psychotropic medications were used in the past and why were they discontinued?

Were there any psychiatric hospitalizations?

Recommendations for the care provider:

Are there any issues to be resolved?

Intake completed by: ___________________________ Date: ___________________________

Information provided by: ___________________________

Relationship to the individual: ___________________________
## DDDS FALL RISK ASSESSMENT TOOL

**Name of Person:** ____________________________  
**MCI #:** ____________________________

**Person’s Address:** ____________________________  
**Person’s DOB:** ____________________________

**Provider:** ____________________________

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Circle appropriate response per category, then add total points

<table>
<thead>
<tr>
<th>Points</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
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<tbody>
<tr>
<td><strong>Age</strong></td>
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<tr>
<td>50 or below</td>
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<td>51 to 60</td>
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<td>70 or above</td>
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**Mental Status**
- 0: Oriented, cooperative
- 1: Oriented, uncooperative or depressed / agitated
- 3: Confused, not oriented

**Physical Status**
- 0: Well
- 1: Documented orthostasis
- 2: Dizziness, Vertigo, Syncope
- 3: Cachexia, Wasting

**Elimination**
- 0: Independent, continent
- 1: Catheter or ostomy
- 2: Elimination with assistance; diarrhea or incontinent
- 3: Independent but incontinent; urgency / frequency

**Sensory**
- 0: No vision or hearing issues
- 1: Hearing loss only
- 2: Vision loss only
- 3: Hearing and Vision Loss

**Neuromotor**
- 0: No paralysis or spasticity
- 1: Upper extremity only
- 2: Lower extremity only
- 3: Both upper and lower

**Gait**
- 0: Unable to walk / stand (not at risk), or fully ambulated
- 1: Physically unable to walk / stand (but may attempt to)
- 2: Walks with help (e.g. mobility aids; cane, walker, holds onto furniture, etc.)
- 3: Balance problems – walking or standing; unsteady gait

**Fall History, past 6 months**
- 0: None
- 1: Near falls or fear of falling
- 2: Has fallen one or two times
- 3: Multiple falls (more than two)

**Medications**
- 0: None below
- 1: 1 med below
- 2: 2 meds below
- 3: 3 or more

Circle: alcohol, anesthetic, antihypertensive, anti-seizure, benzodiazepine, diuretics, cathartics, hypoglycemics, narcotics, psychotropics, sedative / hypnotics

**Subtotal Points**

**Total Points**

0-5 points: Low Risk; 6-10 points: Moderate Risk; 10 or more points: High Risk

* If the person scores 6 or more than implement the Safety Section of the ELP

---

**Signature of Nurse:** ____________________________  
**Date:** ____________________________

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*Approved 08/20/08
Form # 28/CS*
Agreement to Forward Benefit Check(s) Monies

I, ____________________________________________, agree to pay the DDDS for the total amount of ___________________________‘s Social Security/SSI benefit check(s) by the 10th of every month, beginning with the first full month of placement. I have signed the Social Security Change of Representative Payee form and may continue to receive ___________________________‘s benefit check for 1-3 months. The benefit check will be used to pay for residential supports.

I understand that failure to forward the benefit check(s) monies is considered fraud and is against the law. Fraud may result in criminal prosecution. The DDDS will promptly notify the Social Security Administration if you do not forward the benefit check(s) while the beneficiary is not in your care.

You should make your check payable to DDDS-Community Services and send it to the following address:
Community Services @ Stockley Center
ATT: Mrs. Meghan Morgan
26351 Patriot’s Way, 101BB
Georgetown, DE 19947

______________________________  ______________________________
Benefit Payee’s Signature  Date

______________________________  ______________________________
Witness’ Signature  Date
Planned and Emergency Residential Placement Request

Name: ______________________________ Date: __________________

Submitted by: _______________________

Requesting options in: _____ shared living _____ agency _____ both
_____ NCC _____ Kent _____ Sussex _____ Any

Attach ICAP and ELP/profile & hand deliver, fax or email to Shared Living/Respite Supervisor

**************************************************************************************************************************

ORDM Use Only

Name: ____________________________ Phone Number _______________________
Comments: ________________________

Name: ____________________________ Phone number _______________________
Comments: ________________________

Name: ____________________________ Phone number _______________________
Comments: ________________________

**************************************************************************************************************************

Region Use Only

Need more options __________________

Placement match confirmation (individual selects provider & provider accepts individual): __________________

C reviewed 08/20/08
Form # 29/CS
INTAKE NURSING ELP ASSESSMENT

Name ___________________________ Date of Birth _______ Date ____________

Weight ___________ Height ___________ MCI#: ____________________________

Name & Relationship of Informant ________________________________________

1. Since birth: Any major illnesses, accidents, injuries, surgeries, health problems, seizures, sensory observations, allergies

2. Childhood Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
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<tbody>
<tr>
<td>Pertussis</td>
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<tr>
<td>Measles</td>
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<tr>
<td>Other</td>
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3. Immunizations

<table>
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<tr>
<th>DPT/DT (circle one)</th>
<th>Dates of Immunizations / Tests</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Polio</td>
<td></td>
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<tr>
<td>Tetanus Toxoid</td>
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<tr>
<td>Rubella</td>
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<td>Measles</td>
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<td>Mumps</td>
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<td>Influenza</td>
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<td>TB Testing</td>
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<td>Small Pox</td>
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<td>Other</td>
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## Intake Nursing ELP Assessment

### Current Physicians

<table>
<thead>
<tr>
<th>Doctor, Address, Phone &amp; Fax Number</th>
<th>Specialty</th>
<th>Frequency of Visits</th>
<th>Date Last Seen</th>
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### Current Medications

<table>
<thead>
<tr>
<th>Current Medications</th>
<th>What It Is Used For...</th>
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INTAKE NURSING ELP ASSESSMENT

Name ____________________________

5. Significant Family History

Mother: ____________________________

Father: ____________________________

Sibling: ____________________________

6. Current Health Concerns

__________________________
Nurse Signature

__________________________
Date

08/20/08
09/CS/SP
PARC Revised:
INDIVIDUAL PROFILE

1. INFORMATION ABOUT YOU (the person applying for DDDS services)

Name:_________________________  Birthdate:_________________________

Sex (Male / Female):_________________________  Phone No.:_________________________

Your primary Caretaker if other than yourself:

Name:____________________________________

Address:____________________________________

Phone Number:_________________________  Relationship to you:_________________________

Race/Ethnicity:  
_____ White/Caucasian  
_____ Black/African American  
_____ Oriental/Vietnamese  
_____ American Indian  
_____ Spanish Origin  
_____ Other (Specify)_________________________

Religious Preference:  
_____ Christian  
_____ Jewish  
_____ Muslim  
_____ Buddhist  
_____ Hindu  
_____ Other (Specify)_________________________

INFORMATION ABOUT YOUR FAMILY

Name of Mother:_________________________

Birth date & Social Security # of Mother:_________________________

Name of Father:_________________________

Birth date & Social Security # of Father:_________________________

Do you have a genetic disorder?  
☐ No  ☐ Yes (please describe)_________________________

Did any of the following problems or conditions exist during your mother’s pregnancy?

☐ Bleeding  ☐ Infections  ☐ Diseases  ☐ X-Ray Exams

☐ Shock  ☐ Drug Use  ☐ Falls  ☐ Strain (physical, mental, emotional)
2. ABOUT YOUR BIRTH
Were there any difficulties with your birth? □ No □ Yes
If yes, please explain:

Were you: □ Full term □ Premature (how many months were you when born?)
Was anesthesia used during your birth? □ Yes □ No □ Not Sure
Were instruments used? □ Yes □ No □ Not Sure
Did you cry at once? □ Yes □ No □ Not Sure
Were you jaundiced (yellow) at birth or soon after? □ Yes □ No □ Not Sure
If yes, for how long? __________________________________________
Did you require special treatment to help with breathing? (injections, oxygen, etc.)
□ Yes □ No □ Not Sure

What was your weight at birth? ____________________________________

3. ABOUT YOUR DEVELOPMENT
Did you ever receive early childhood intervention services? □ Yes □ No
Please tell us how old you were when the following Developmental Milestones happened for you:
Teething __________ Sitting Alone __________ Standing Alone __________
Walking Alone ______ Beginning to Talk _______ Toilet Trained ______

4. SCHOOL HISTORY
What school did you last attend?
Name ________________________________ Phone: ____________________
Address: ______________________________

Last Grade attended: ____________________________
5. TEST HISTORY

Date of your last psychological test? ____________________________________________

Who tested you, and where? ____________________________________________

6. WORK HISTORY

<table>
<thead>
<tr>
<th>Where Have You Worked?</th>
<th>What Type of Work Did You Do?</th>
<th>When Did You Work There? (Dates)</th>
</tr>
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7. SERVICE HISTORY: Do you or have you received services from any of the following (please check all that apply)

A.I. DuPont Institute
Child Development Watch
Division of Child Mental Health
Delaware Autistic Program
Delaware Psychiatric Hospital
Division of Family Services
DDDS (Respite-Residential)
Governor Bacon
Elwyn
Kent-Sussex Industries
Meadowood Hospital

<table>
<thead>
<tr>
<th>Current</th>
<th>Past</th>
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8. CRIMINAL HISTORY
Have you ever been convicted of a criminal offense (Felony or Class A Misdemeanor)? □ Yes □ No
If yes, tell us the type of offense, date & location: ____________________________

Are you currently on probation or parole? □ Yes □ No
Comment, if yes: ____________________________

Name and phone number of probation officer: ____________________________

9. PSYCHIATRIC HISTORY
Have you ever received out-patient psychiatric treatment? □ Yes □ No
Name and address of physician: ____________________________

Dates of Treatment: ____________________________

Have you ever received in-patient psychiatric treatment? □ Yes □ No
Name and address of facility: ____________________________

Dates of Treatment: ____________________________

10. CURRENT MEDICATIONS
Please tell us about all the medicines you are taking. Please continue on back of next page if needed.

Medication: ____________________________
Circle: President or Non-Prescription
Reason Given: ____________________________

How do you take it: ____________________________

Medication: ____________________________
Circle: President or Non-Prescription
Reason Given: ____________________________
How do you take it: ________________________________________________

Medication: ______________________________________________________
Circle: Prescription or Non-Prescription
Reason Given: ____________________________________________________
How do you take it: ________________________________________________

Person Helping You Complete This Profile: _____________________________ Phone: __________________

Person Providing the Information: _________________________________ Phone: __________________

Date Of Completion: _____________________________________________

**Required Signatures:**

Signature of Individual Seeking Services _________________________________

Signature of Guardian/Family Member *(if applicable)* ____________________
Please do not leave any spaces blank. Write N/A if not applicable.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Name of residential placement w/agency name</th>
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<tbody>
<tr>
<td>Date of Birth</td>
<td>Name of day program placement w/agency name</td>
</tr>
<tr>
<td>Address (Street)</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Address (City, State, Zip)</td>
<td>C.M. Phone # &amp; e-mail address</td>
</tr>
<tr>
<td>Phone Numbers</td>
<td>Parent/Surrogate/Guardian</td>
</tr>
<tr>
<td>Social Security #</td>
<td>Phone #</td>
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</tbody>
</table>

Prescription Medication List (do not include dosage) | Purpose of prescription medication (why was it prescribed?)
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List 3 respondents who have had regular contact with the person (5 times a week), in the last three months, including residential provider, day program employee and a family member, if applicable. Include an explanation if the 3 required respondents are not available or not applicable.

<table>
<thead>
<tr>
<th>Name &amp; Relationship</th>
<th>Daytime contact phone number</th>
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Please attach the following documents:

- Most current Psychological Evaluation (must include IQ testing results/scores)
- Most current Physical Examination
- Original Nursing Assessment/Nursing Intake ELP
- Psychiatric Evaluation for persons receiving psychiatric services

All ICAP requests must be reviewed and initialed by the RPD/Designee prior to submission.

IC Approved: 08/20/08
Form # 30/CS