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

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local