District of Columbia Government

A Path to Community Living

A Publication of the

Office of Disability Rights

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The mission of the DC Office of Disability Rights (ODR) is to ensure that the programs, services, benefits, activities and facilities operated or funded by the District of Columbia are fully accessible to, and useable by people with disabilities. ODR is committed to inclusion, community-based services, and self-determination for people with disabilities. ODR is responsible for overseeing the implementation of the City's obligations under the Americans with Disabilities Act (ADA), as well as other disability rights laws.

ODR Services:

• Informal dispute resolution of discrimination complaints

• Training, Technical Assistance and Information and Referral

• Policy and budget recommendations for improving District access to persons with disabilities.

**This document is available in alternate formats.**

**Please contact ODR for assistance.Table of Contents**

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**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❒ I identify as a man.

❒ I identify as a woman.

❒ I identify in some other way.

This handbook is designed to assist people who have moved or are planning to move out of institutions into the community of their choice. These forms are designed to help you identify the services and supports you **may** need to successfully live in the community.

**This information is only for you. You may choose to share it with a relative, case manager, or friend. You may want to consider this information to be personal and private. However, if you share it with anyone it may no longer be private. It is up to you!**

This handbook is designed to be used by anyone. Please note that all sections or requested information may not apply to your situation. Everyone is entitled to define and design their future.

**Where Do You Currently Live?**

|  |
| --- |
| **Contact information for Your Housing** |
| 1. | Street Address: |  |
| 2. | County (if applicable): |  |
| 3. | City: |  |
| 4. | State: |  |
| 5. | Zip Code: |  |
| 6. | Phone: |  |

**Family and Social Supports**

Provide the contact information for your family and friends that may provide support to you.

|  |  |  |
| --- | --- | --- |
|  | **Name and Relationship** | **Contact Information** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |

**What Are Your Interests?**

Complete the following checklist regarding your plans for typical daily activities and check activities that you may participate in or want to participate in.

❒ Employment ❒ Recreation activities

❒ School ❒ Youth activities

❒ Work readiness program ❒ Reading

❒ Faith based activities ❒ Dancing

❒ Sports ❒ Cooking

❒ Exercise group ❒ Shopping

❒ Senior activities ❒ Cleaning

❒ Theater/Performing Arts ❒ Sewing

❒ Music ❒ Games

❒ Movies ❒ AA / NA

❒ Art ❒ Photography

❒ Arts and Crafts ❒ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_

❒ Visiting Family & Friends

❒ Watching TV

❒ Using Computers

❒ Sightseeing

❒ Gardening

❒ Hobby (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Top Goals**

Things that are important to you. Be creative.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Income (Money), Benefits, and Health Care**

Please fill out the information based on what you know at this time. For income, please enter amounts, if you know them, on the lines provided. Some of the resource categories may not apply to you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Money/Financial Benefits****Do you have?** | **Yes** | **No** | **I Don’t Know** |
| 1. | Supplemental Security Income (SSI)Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 2. | Social Security Disability Insurance (SSDI)Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 3. | Social Security Retirement or Survivor’s Benefits (SS)Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 4. | Veteran’s BenefitsAmount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 5. | Retirement PensionAmount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 6. | Court Settlement, Annuity, or Special Needs Trust IncomeAmount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 7. | WagesAmount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 8. | Interim Disability Assistance (IDA)Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 9. | Food Stamps/SNAP BenefitsAmount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 10. | Other Income (specify):Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  | **Healthcare Benefits****Do you have…?** | **Yes** |  **No** | **I Don’t Know** |
| 11. | DC Medicaid |  |  |  |
| 12. | Medicaid (other state specify): |  |  |  |
| 13. | Managed Care Program1. DC Chartered Health Plan
2. Healthcare Services for Children with Special Needs (HSCSN)
3. United Healthcare
 |  |  |  |
| 14. | Medicare Part A (Hospital) |  |  |  |
| 15. | Medicare Part B (Prescription Drug) |  |  |  |
| 16. | Medicare Part D (Outpatient) |  |  |  |
| 17. | Veteran’s Assistance Health Benefits |  |  |  |
| 18. | Private Health Insurance |  |  |  |
| 19. | CHAMPUS |  |  |  |
| 20. | DC Government Pharmacy Assistance |  |  |  |
| 21. | Other Health Benefits A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_C.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Help With Making Decisions**

A guardian is someone that has been appointed to help you make decisions about your life. There are different types of Guardianships. If you have a guardian, please fill out the Guardianship Contact Information table below:

**Types of Guardianship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Type of Guardianship** | **Yes, I Have** | **No, I Don’t Have** | **I Don’t Know** |
| 1. | Guardian for all decisions |  |  |  |
| 2. | Guardian for medical care decisions |  |  |  |
| 3. | Guardian for financial or money decisions |  |  |  |
| 4. | Guardian for other \_\_\_\_\_\_\_\_\_\_\_\_ decisions |  |  |  |

|  |  |
| --- | --- |
| **My Legal Guardian is:** | **Contact Information** |
|  |  |

**Health History and Medical Conditions**

Please check the boxes that apply to you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Condition or Diagnosis** | **Yes, I Have** | **No, I Don’t Have** | **I Don’t Know** |
| 1. | Allergies (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 2. | Alzheimer’s |  |  |  |
| 3. | Anemia |  |  |  |
| 4. | Arthritis |  |  |  |
| 5. | Asthma |  |  |  |
| 6. | Autism |  |  |  |
| 7. | Bipolar Disorder |  |  |  |
| 8. | Cancer (type)\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 9. | Cardiac Dysrhythmia  |  |  |  |
| 10. | Cataracts |  |  |  |
| 11. | Dementia |  |  |  |
| 12. | Depression |  |  |  |
| 13. | Diabetes (Controlled) |  |  |  |
| 14. | Diabetes (Uncontrolled) |  |  |  |
| 15. | Eating Disorder |  |  |  |
| 16. | Emphysema  |  |  |  |
| 17.. | Glaucoma |  |  |  |
| 18. | Heart Disease |  |  |  |
| 19. | Heart Failure |  |  |  |
| 20. | HIV (AIDS) |  |  |  |
| 21. | Hypertension |  |  |  |
| 22. | Lung Disease |  |  |  |
| 23. | Multiple Sclerosis |  |  |  |
| 24. | Osteoporosis |  |  |  |
| 25. | Parkinson’s Disease |  |  |  |
| 26. | Pneumonia |  |  |  |
| 27. | Kidney Disease |  |  |  |
| 28. | Schizophrenia |  |  |  |
| 29. | Spinal Cord Injury |  |  |  |
| 30. | Stroke |  |  |  |
| 31. | Traumatic Brain Injury (TBI) |  |  |  |
| 32. | Tuberculosis (TB) |  |  |  |
| 33. | Urinary Tract Infection (recurrent) |  |  |  |
| 34. | Circulatory Issues |  |  |  |
| 35. | Other Health Condition (s)(type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Disability Information**

Please complete the table regarding your history of disability: Please include information in multiple categories if appropriate.

|  |  |
| --- | --- |
| **Disability Information** |  |
|  | **Disability Type** | **Yes** | **No** | **I Don’t Know** |
| 1. | Mental Health Condition |  |  |  |
| 2. | Seizure Disorder |  |  |  |
| 3. | Epilepsy |  |  |  |
| 4. | Developmental Disability |  |  |  |
| 5. | Deaf/Hard of Hearing |  |  |  |
| 6. | Intellectual Disability |  |  |  |
| 7. | Mobility Disability |  |  |  |
| 8. | Blind/Low Vision |  |  |  |
| 9. | Sensory Disability |  |  |  |
| 10. | Learning Disability |  |  |  |
| 11. | Speech Disability |  |  |  |
| 12. | Other Disability (specify)A.\_\_\_\_\_\_\_\_\_\_\_\_\_B.\_\_\_\_\_\_\_\_\_\_\_\_\_C.\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Other Health Issues**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Health Issue** | **Yes** | **No** | **I Don’t Know** |
| 1. | Memory Loss |  |  |  |
| 2. | Difficulty Organizing or Planning |  |  |  |
| 3. | Aggression |  |  |  |
| 4. | Wandering |  |  |  |
| 5. | Hurting Myself |  |  |  |
| 6. | Verbally Abusive |  |  |  |
| 7. | Refusal to Eat or Drink |  |  |  |
| 8. | Refusal to take Medication |  |  |  |
| 9. | Speech Difficulty |  |  |  |
| 10. | Low Vision |  |  |  |
| 11. | Bladder Control |  |  |  |
| 12. | Bowel Control |  |  |  |
| 13. | Pressure Sore |  |  |  |
| 14. | Oral Health or Dental Issues (Teeth) |  |  |  |
| 15. | Skin Condition |  |  |  |
| 16. | Balance |  |  |  |
| 17. | Paralysis |  |  |  |
| 18. | Hand Coordination |  |  |  |
| 19. | Amputation (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 20. | Spasms |  |  |  |
| 21. | Other (specify):A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_C.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Wellness Issues**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Medical Care Symptom** | **Yes** | **No** | **I Don’t Know** |
| 1. | Chest Pain |  |  |  |
| 2. | Constipation |  |  |  |
| 3. | Cough |  |  |  |
| 4. | Diarrhea |  |  |  |
| 5. | Difficulty Breathing |  |  |  |
| 6. | Dizziness |  |  |  |
| 7. | Fainting |  |  |  |
| 8. | Fever |  |  |  |
| 9. | Headache |  |  |  |
| 10. | Indigestion or Vomiting |  |  |  |
| 11. | Joint Pain |  |  |  |
| 12. | Malnutrition |  |  |  |
| 13. | Obesity |  |  |  |
| 14. | Chronic Pain |  |  |  |
| 15. | Paralysis |  |  |  |
| 16. | Weakness |  |  |  |
| 17. | Other (specify): |  |  |  |

**Sexual Health**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Sexual Health** | **Yes** | **No** | **I Don’t Know** |
| 1. | I am sexually active. |  |  |  |
| 2. | I need information about STDs (Sexually Transmitted Diseases). |  |  |  |
| 3. | I need information about safe sex. |  |  |  |
| 4. | I need information about birth control. |  |  |  |
| 5. | I need information about STD testing near me. |  |  |  |
|  | I need information about other (specify):\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**I Need More Information About:**

❒ Male Condoms ❒ Vaginal Contraceptive Rings

❒ Female Condoms ❒ Fertility Awareness Birth Control

❒ Spermicide ❒ Abstinence

❒ Lubricants ❒ Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_

❒ Dental Dams

❒ Diaphragms

❒ Birth Control Pills

❒ Birth Control Patch

❒ Birth Control Shots

❒ Cervical Caps

**Healthcare Services and Supports**

Complete the table and list all healthcare providers who will be routinely seeing you in the community. (Attach pages if needed.)

|  |
| --- |
| **Healthcare Providers** |
| **Primary Care Physician** |
|  | **Name** | **Street Address** | **Telephone/****Email** |
| 1. |  |  |  |
| **Specialty Physicians** |
|  | **Name and Specialty** | **Street Address** | **Telephone /****E-mail** |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| **Therapists** |
|   | **Therapist’s Name and Type of Therapy** | **Street Address** | **Telephone/****E-mail** |
| 7. |  |  |  |
| 8. |  |  |  |
| **Home Health Care** |
|  | **Name** | **Street Address** | **Telephone/****Email** |
| 9. |  |  |  |

**Medication List**

**Include any medications, vitamins, or supplements you may take.**

|  |
| --- |
| **Medication List** |
|  | **Medication** | **Dosage** | **Frequency****Taken** | **Time of Day Taken** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |
| 8. |  |  |  |  |
| 9. |  |  |  |  |
| 10. |  |  |  |  |
| 11. |  |  |  |  |
| 12. |  |  |  |  |

|  |
| --- |
| **Pharmacy information** |
|  | **Pharmacy Name** | **Street Address** | **Telephone Number** |
|  |  |  |  |

**Mental Health**

Please complete the table regarding your history of mental health supports.

|  |  |
| --- | --- |
| **MENTAL Health Supports** |  |
|  | **Mental Health Support** | **Yes**  | **No** | **I Don’t Know** |
| 1. | No Supports Needed: |  |  |  |
| 2. | In Patient Hospitalization |  |  |  |
| 3. | Out Patient Hospitalization or Day Treatment: |  |  |  |
| 4. | Counseling: |  |  |  |
| 5. | Behavior Plan: |  |  |  |
| 6. | Medication Management: |  |  |  |
| 7. | In Patient Drug/Alcohol Treatment: |  |  |  |
| 8. | Out Patient Drug/Alcohol Treatment: |  |  |  |
| 9. | Other Mental Health Support (specify):1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |  |

**Daily Activities**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  **Activity of Daily Living** |  **Yes** | **No** | **I Don’t Know** |
| 1. | I Can Move from Chair to Chair |  |  |  |
| 2. | I Can Get Around Indoors |  |  |  |
| 3. | I Can Get Around Outdoors |  |  |  |
| 4. | I Can Feed Myself  |  |  |  |
| 5. | I Can Toilet Myself |  |  |  |
| 6. | I Can Take My Medication on Time |  |  |  |
| 7. | I Can Self-Shower/Bathe |  |  |  |
| 8. | I Can Dress Myself |  |  |  |
| 9. | Other (specify):A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_C.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Therapies or Other Health Care Services**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Therapy or Health Care Service** | **Yes** | **No** | **I Don’t Know** |
| 1. | Audiology (Hearing) |  |  |  |
| 2. | Occupational Therapy |  |  |  |
| 3. | Physical Therapy |  |  |  |
| 4. | Psychological Counseling |  |  |  |
| 5. | Radiation Therapy |  |  |  |
| 6. | Kidney Dialysis |  |  |  |
| 7. | Respiratory Therapy (breathing) |  |  |  |
| 8. | Speech Therapy |  |  |  |
| 9 | Mental Health Counseling |  |  |  |
| 10. | Other (specify):1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |  |

**Equipment Used or Needed**

Check the column for any item that you use or may need. Use this check list to make plans to get what you need.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Equipment** | **Yes** | **No** | **I Don’t Know** |
| 1. | Power Scooter/Power Wheelchair |  |  |  |
| 2 | Manual Wheelchair  |  |  |  |
| 3. | Power Wheelchair |  |  |  |
| 4. | Shower Chair/Bench  |  |  |  |
| 5. | Brace |  |  |  |
| 7. | Artificial Body Part (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 8. | Crutches/Arm Braces |  |  |  |
| 9. | Cane |  |  |  |
| 10. | Walker |  |  |  |
| 11. | Lift Chair |  |  |  |
| 12. | Transfer Board |  |  |  |
| 13. | Hoyer Lift |  |  |  |
| 14. | Single Bed |  |  |  |
| 15. | Double Bed |  |  |  |
| 16. | Manual Hospital Bed |  |  |  |
| 17. | Automatic Hospital Bed |  |  |  |
| 18. | Hospital Bed (Other) |  |  |  |
| 19. | Bed Rails |  |  |  |
| 20. | Sleep Breathing Device (C PAP) |  |  |  |
| 21. | Therapeutic Mattress |  |  |  |
| 22. | Other (specify):A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_C.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Equipment** | **Yes** | **No** | **I Don’t Know** |
| 23. | I.V. Supplies |  |  |  |
| 24. | Special Utensils |  |  |  |
| 25. | Feeding Tube |  |  |  |
| 26. | Liquid Nutrition |  |  |  |
| 27. | Glasses |  |  |  |
| 28. | Contact Lenses |  |  |  |
| 29. | White Cane |  |  |  |
| 30. | Talking Clock |  |  |  |
| 31. | Magnifying Glass |  |  |  |
| 32. | Hearing Aid |  |  |  |
| 33. | TTY Device |  |  |  |
| 34. | Cell Phone |  |  |  |
| 35. | Communication Board |  |  |  |
| 36. | Calendar |  |  |  |
| 37. | Planner or Organizer  |  |  |  |
| 38. | Programmable Watch |  |  |  |
| 39. | Blood Sugar Level Monitor |  |  |  |
| 40. | Syringes |  |  |  |
| 41. | Blood Sugar Test Strips |  |  |  |
| 42. | Lancets |  |  |  |
| 43. | Alcohol Swabs |  |  |  |
| 44. | Home Oxygen |  |  |  |
| 45. | Tracheotomy Ventilation System |  |  |  |
| 46. | Modifications for Allergies |  |  |  |
| 47. | Other (specify):A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_C.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Legal History and Background**

Please answer the following questions regarding your legal history and criminal background history. .

|  |  |
| --- | --- |
| **Legal History and Background** |  |
|  | **Question** | **Yes** | **No** | **I Don’t Know** |
| 1. | Have you ever filed for bankruptcy? |  |  |  |
| 2. | Have you ever been evicted? |  |  |  |
| 3. | Have you ever been arrested? |  |  |  |
| 4. | Have you ever gone to jail? |  |  |  |
| 5. | Have you ever been convicted of a felony offense as an adult? |  |  |  |
| 6. | Do you have parole, probation officer or other court ordered obligations? |  |  |  |
| 7. | Are you required to register as a sex offender? |  |  |  |

**Transportation Needs Plan**

**Location of Public Transportation and Neighborhood Services**

Please check where you would like to live.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **I Need to Live Close To:** | **Yes** |  **No** | **I Don’t Know** |
| 1. | A Metro Bus Stop |  |  |  |
| 2. | A Metro Rail Station |  |  |  |
| 3. | A Grocery Store |  |  |  |
| 4. | A Pharmacy |  |  |  |
| 5. | A BankA place of worship My Job:Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_: |  |  |  |

**Transportation Assistance and Supports**

Please check any transportation assistance and/or supports that you may need to travel in the community.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Transportation Assistance and Support** |  **Yes** | **No** | **I Don’t Know** |
| 1. | Training to use the bus |  |  |  |
| 2. | Training to use the Metro |  |  |  |
| 3. | Apply for eligibility for para transit service (Metro Access) |  |  |  |
| 4. | Apply for Reduced Fare Card |  |  |  |
| 5. | Need wheelchair lift equipped vehicle |  |  |  |
| 6 | Need Assistance to transfer in and out of vehicle |  |  |  |
| 7. | Need an attendant to travel with me |  |  |  |
| 8. | Need referral for medical transportation |  |  |  |
| 9. | Need referral for non-medical private transportation |  |  |  |
| 10. | Need orientation and mobility training for people with low vision or blindness |  |  |  |
| 11. | Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

Please complete the following table regarding you plans to meet your transportation needs in the community.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Mode of Transportation** | **Yes** | **No** | **I Don’t Know** |
| 1. | Metro Bus |  |  |  |
| 2. | Metro Rail |  |  |  |
| 3. | Para transit or Metro Access  |  |  |  |
| 4. | Ride with Family or Friends |  |  |  |
| 5. | Taxi |  |  |  |
| 6. | Other (specifiy): |  |  |  |

**Financial (Money) Information and Services**

Please complete the following information regarding your personal finances and income.

|  |  |
| --- | --- |
| **Financial Services** |  |
|  | **Question** | **Yes** | **No** | **I Don’t Know** |
| 1. | Do you have a Representative Payee for entitlements or benefits? |  |  |  |
| 2. | Do you need a financial guardian? |  |  |  |
| 3. | Do you need a bank account? |  |  |  |
| 4. | Do you need to set up direct deposit for wages or benefits? |  |  |  |
| 5. | Do you need help paying your monthly bills? |  |  |  |

**Housing**

Do you have the following documents?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Document** | **Yes** | **No** | **I Don’t Know** |
| 1. | Birth Certificate/Passport |  |  |  |
| 2. | Social Security Card |  |  |  |
| 3. | Photo ID/ Driver’s License  |  |  |  |
| 4. | Written Proof of Income |  |  |  |

Complete the table and requested information below and indicate your preferences for a community based living arrangement.

|  |  |
| --- | --- |
| **MY Housing Preference** |  |
|  | **Living Arrangement** | **Yes** | **No** | **I Don’t Know** |
| 1. | Living Alone |  |  |  |
| 2. | Living with Non-Relatives |  |  |  |
| 3. | Live with Relatives in their Home |  |  |  |
| 4. | Foster Care |  |  |  |
| 5. | Assisted Living Community |  |  |  |
| 6. | Other (specify)::\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Accessibility Requirements for Housing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Accessibility Requirement** | **Yes** | **No** | **I Don’t Know** |
| 1. | Wide Doorways |  |  |  |
| 2. | Level Entrance  |  |  |  |
| 3. | No Stairs |  |  |  |
| 4. | Bathroom Grab Bars |  |  |  |
| 5. | Roll-In Shower  |  |  |  |
| 6. | Hallway Rail |  |  |  |
| 7. | Automatic Door Opener |  |  |  |
| 8. | Raised or Lowered Countertops |  |  |  |
| 9. | Raised Toilet |  |  |  |
| 10. | Chairlift  |  |  |  |
| 11. | Outdoor Ramp |  |  |  |
| 12. | Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Your Next Steps**

**Please review the information you have completed in previous sections and list the things that you would like more information about.**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List the people who can help you get this information. f**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List the things that you know you can do right now to help yourself achieve your top goals.**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\**