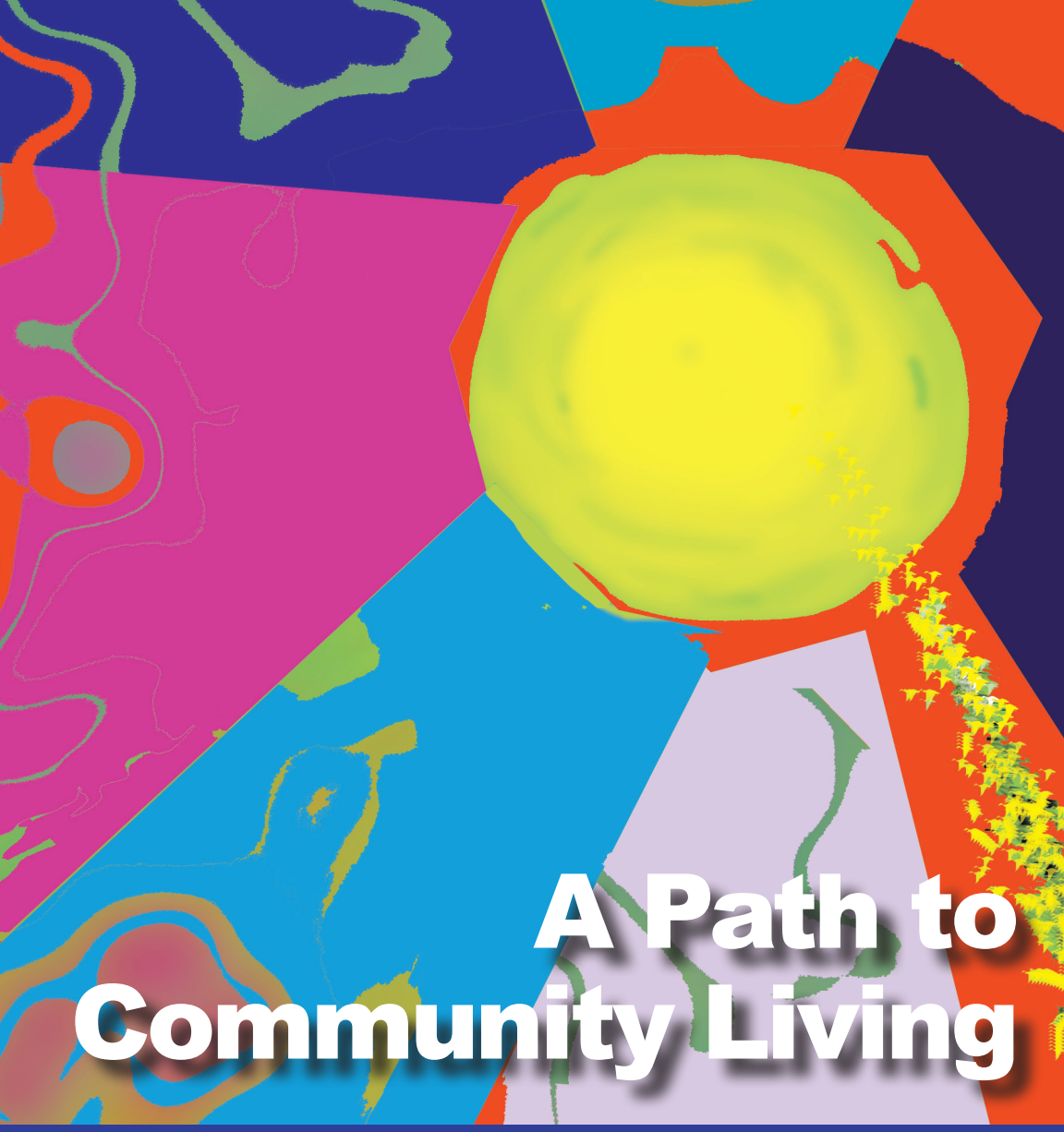

A Path to Community Living

Office of Disability Rights

2012

GOVERNMENT OF THE
DISTRICT OF COLUMBIA
VINCENT C. GRAY. MAYOR

ODR

District of Columbia **Office of Disability Rights**

Contact

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** Models displayed in the images may not have been people of disability. Their appearance are displayed for illustration purposes.

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

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
- ☐ School
- ☐ Work readiness program
- ☐ Faith based activities
- ☐ Sports
- ☐ Exercise group
- ☐ Senior activities
- ☐ Theater/Performing Arts
- ☐ Music
- ☐ Movies
- ☐ Art
- ☐ Arts and Crafts
- ☐ Visiting Family & Friends
- ☐ Watching TV
- ☐ Hobby (specify):_____
- ☐ Other (specify):_____
- ☐ Recreation activities
- ☐ Youth activities
- ☐ Reading
- ☐ Dancing
- ☐ Cooking
- ☐ Shopping
- ☐ Cleaning
- ☐ Sewing
- ☐ Games
- ☐ AA / NA
- ☐ Photography
- ☐ Gardening
- ☐ Sightseeing
- ☐ Using Computers

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 Dis-ability Insurance (SSDI) Amount:_____			
3.	Social Security Retirement or Survivor's Benefits (SS) Amount:_____			
4.	Veteran's Benefits Amount:_____			
5.	Retirement Pension Amount:_____			
6.	Court Settlement, Annuity, or Special Needs Trust Income Amount:_____			
7.	Wages Amount:_____			
8.	Interim Disability Assistance (IDA) Amount:_____			
9.	Food Stamps/SNAP Benefits Amount:_____			
10.	Other Income (specify): Amount:_____			

Continued on next page

Benefits, and Health Care

Please fill out the information based on what you know at this time. Some of the resource categories may not apply to you.

	Healthcare Benefits Do you have…?	Yes	No	I Don't Know
11.	DC Medicaid			
12.	Medicaid (other state specify):			
13.	Managed Care Program A. DC Chartered Health Plan B. Healthcare Services for Children with Special Needs (HSCSN) C. 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 below:

	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			

Continued on next page

Health History and Medical Conditions

	Condition or Diagnosis	Yes, I Have	No, I Don't Have	I Don't Know
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 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

Please check the boxes that apply to you.

	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

Please check the boxes that apply to you.

	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

Please check the boxes that apply to you.

	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.			
6.	I need information about other (specify):			

I Need More Information About:

☐ Male Condoms

☐ Female Condoms

☐ Spermicide

☐ Lubricants

☐ Dental Dams

☐ Diaphragms

☐ Birth Control Pills

☐ Birth Control Patch

☐ Birth Control Shots

☐ Cervical Caps

☐ Vaginal Contraceptive Rings

☐ Fertility Awareness Birth Control

☐ Abstinence

☐ Other (specify)_____

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/ Email
2.			
3.			
4.			
5.			
6.			
Therapists			
	Name and Therapy Type	Street Address	Telephone/ Email
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	Yes	No	I Don't Know
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

PHARMACY INFORMATION		
Pharmacy Name	Street Address	Telephone

Mental Health

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

MEDICATION LIST				
	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): 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): A. _____ B. _____ C. _____			

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. _____			

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			
6.	Artificial Body Part (specify):			
7.	Crutches/Arm Braces			
8.	Cane			
9.	Walker			
10.	Lift Chair			
11.	Transfer Board			
12.	Hoyer Lift			
13.	Single Bed			
14.	Double Bed			
15.	Manual Hospital Bed			
16.	Automatic Hospital Bed			
17.	Hospital Bed (Other)			
18.	Bed Rails			
19.	Sleep Breathing Device (C PAP)			
20.	Therapeutic Mattress			
21.	I.V. Supplies			
22.	Special Utensils			
23.	Feeding Tube			

Continued on next page

Equipment Used or Needed

	EQUIPMENT	Yes	No	I Don't Know
24.	Liquid Nutrition			
25.	Glasses			
26.	Contact Lenses			
27.	White Cane			
28.	Talking Clock			
29.	Magnifying Glass			
30.	Hearing Aid			
31.	TTY Device			
32.	Cell Phone			
33.	Communication Board			
34.	Calendar			
35.	Planner or Organizer			
36.	Programmable Watch			
37.	Blood Sugar Level Monitor			
38.	Syringes			
39.	Blood Sugar Test Strips			
40.	Lancets			
41.	Alcohol Swabs			
42.	Home Oxygen			
43.	Tracheotomy Ventilation System			
44.	Modifications for Allergies			
45.	Other (specify): A._____ B._____ C._____			

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 Bank A place of worship My Job: Other (specify):			

Transportation Assistance and Supports

Please complete the following tables regarding transportation plans, 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):			

	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?			

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?			

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.

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. _____

Notes

Notes

Office of Disability Rights

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