DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DOVER, DELAWARE

Title: Emergency Temporary Living Arrangements Policy **Approved By:** *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 Formshall 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.

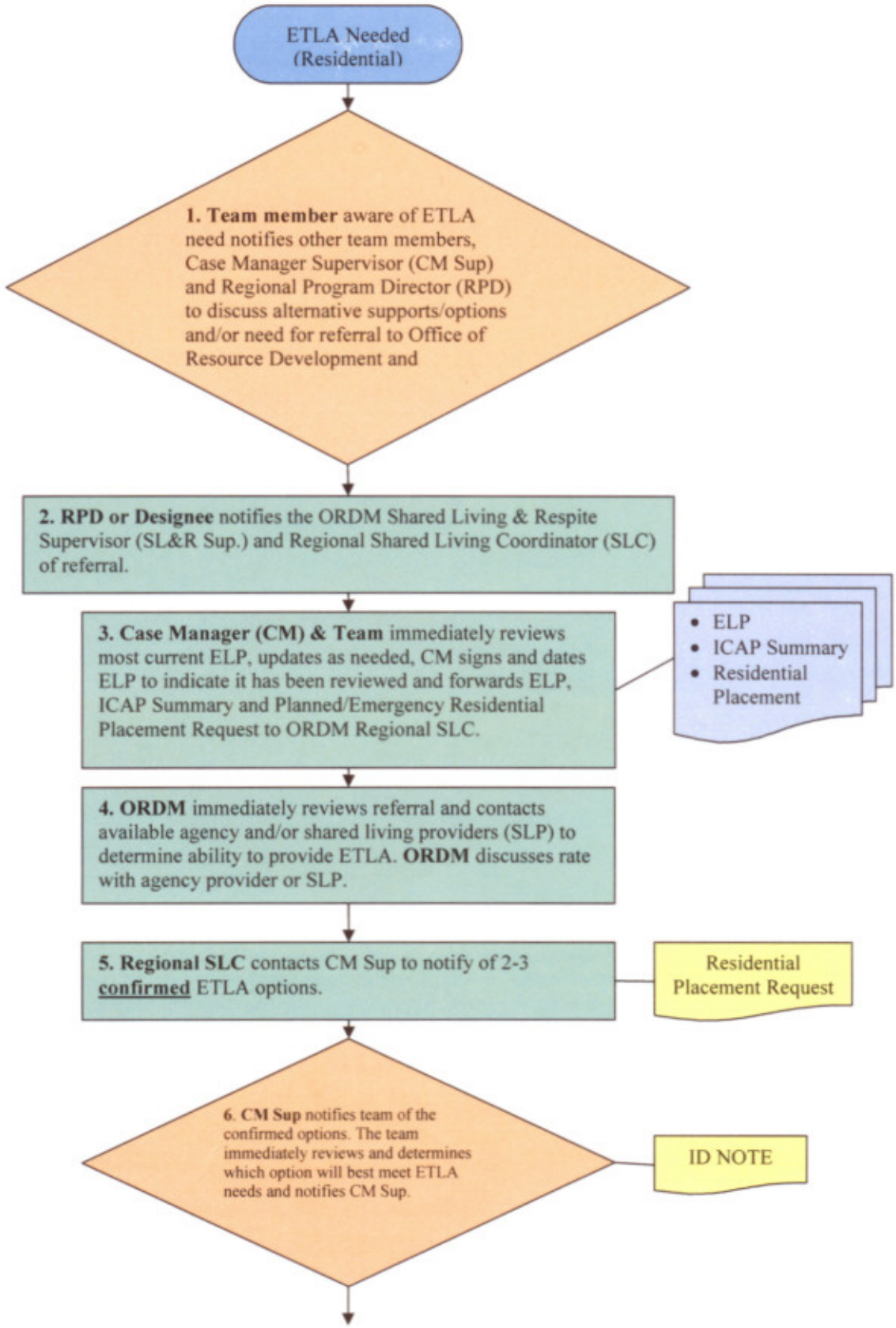
K. From the time the individual begins the ETLA placement, documentation shall be maintained as if the placement is a permanent admission.

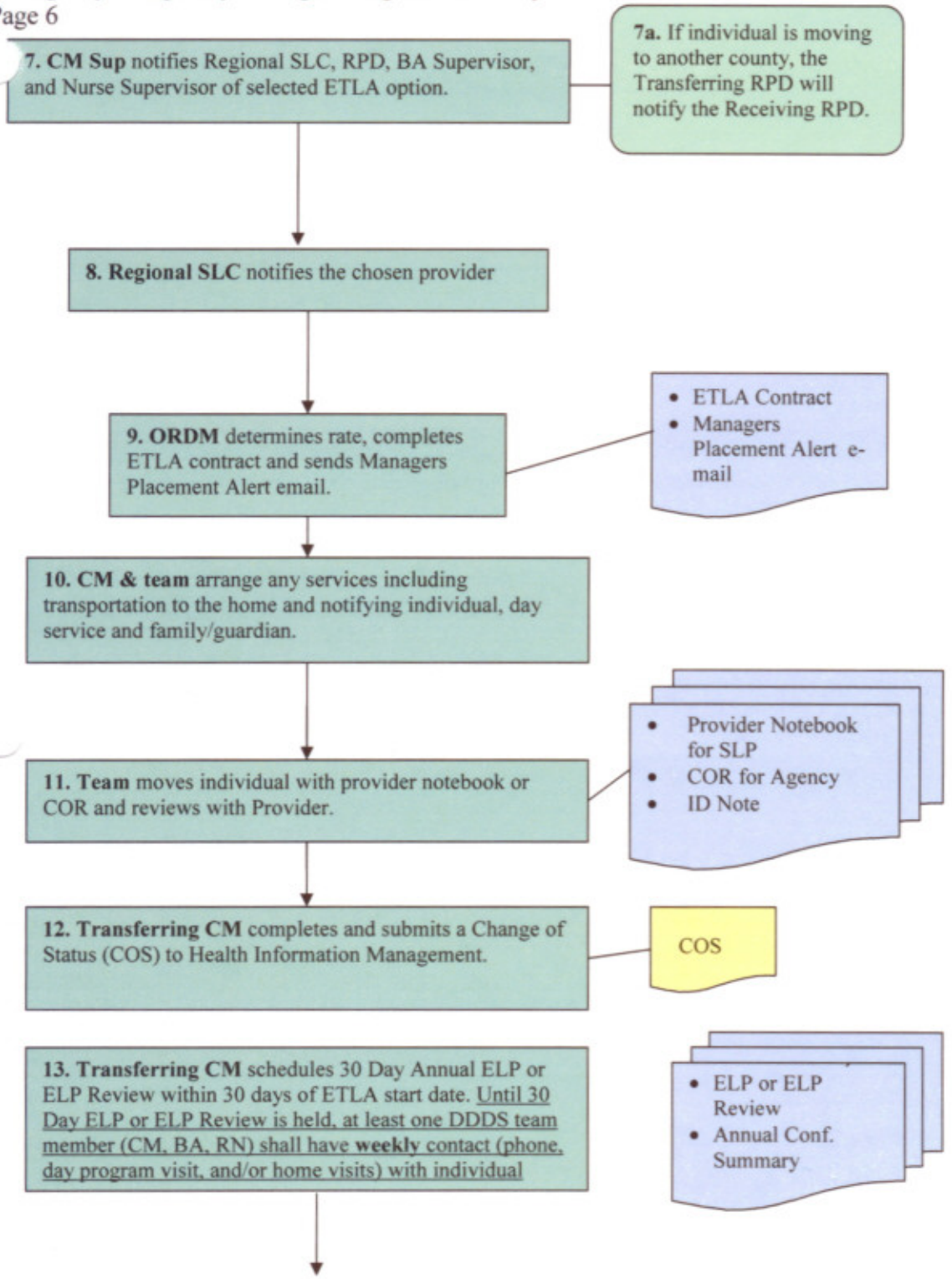
L. Individuals admitted to ETLA shall be assessed for unsupervised time within two (2) business days of his/her move. Individuals shall not be unsupervised until the assessment is completed.

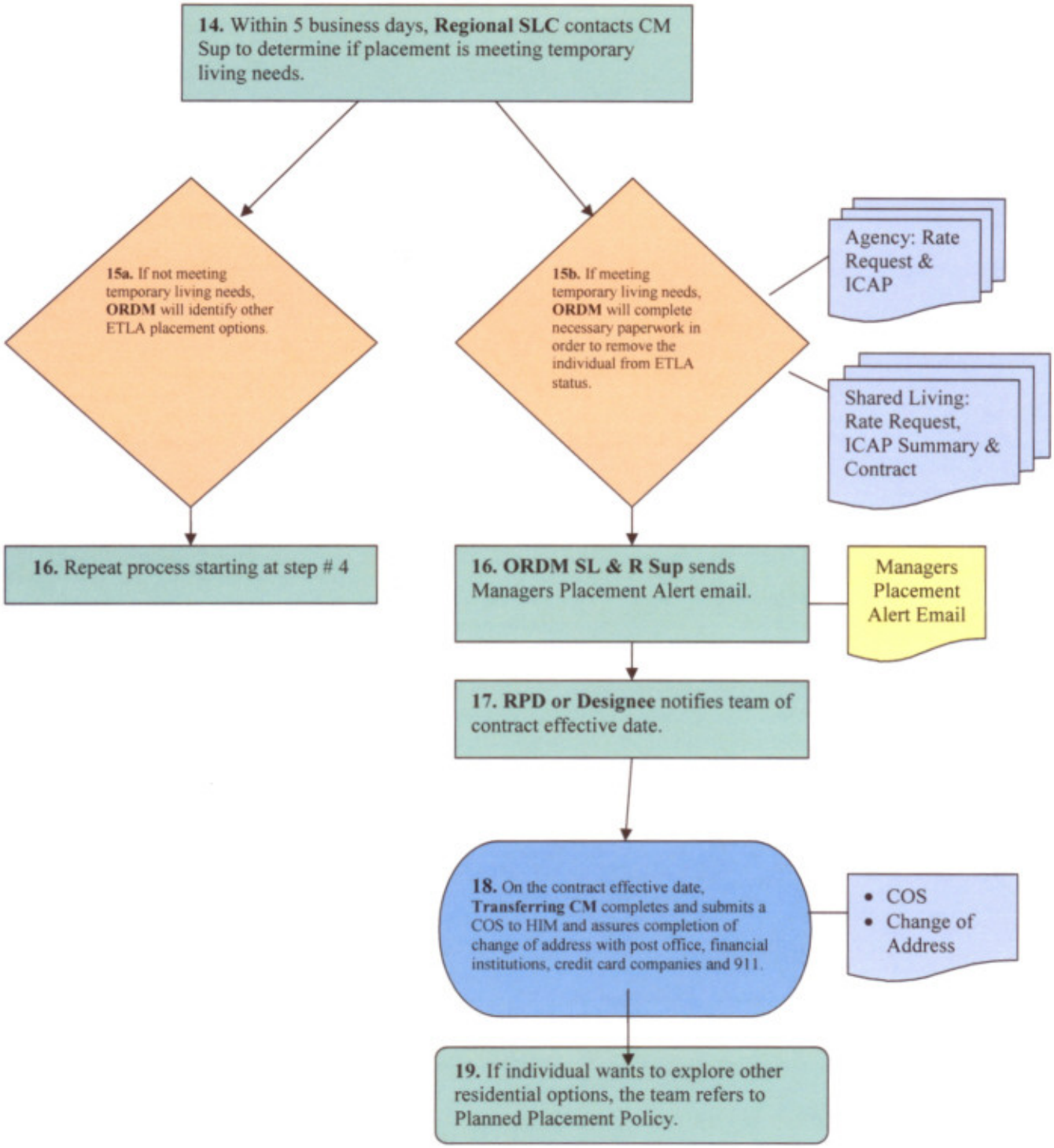
M. The DDDS team members and the Office of Resource Development and Management shall work towards a permanent residential solution within a maximum of 60 days of admission to the ETLA placement.

VI. PROCEDURES

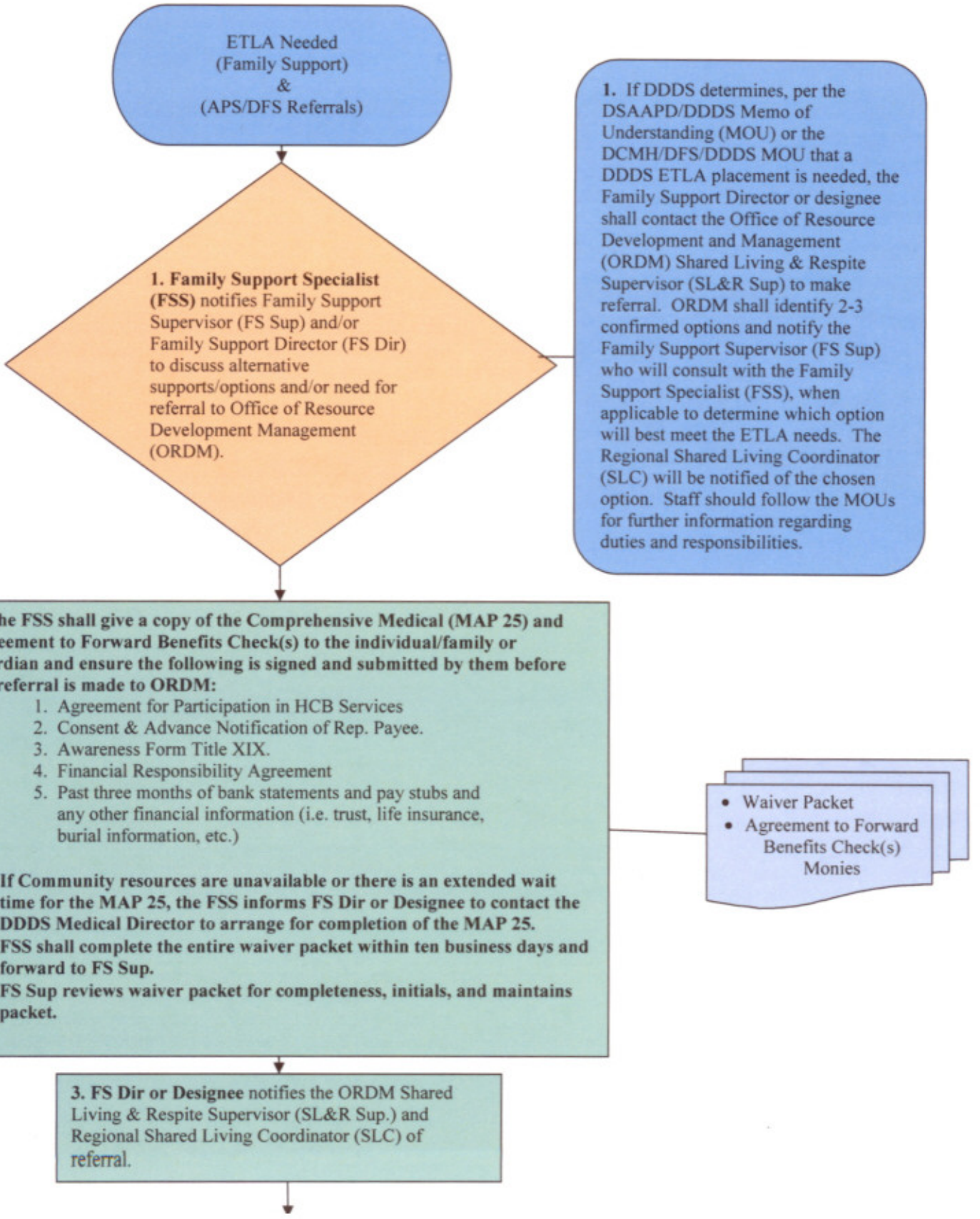
ETLA Needed from Current Residential Placement

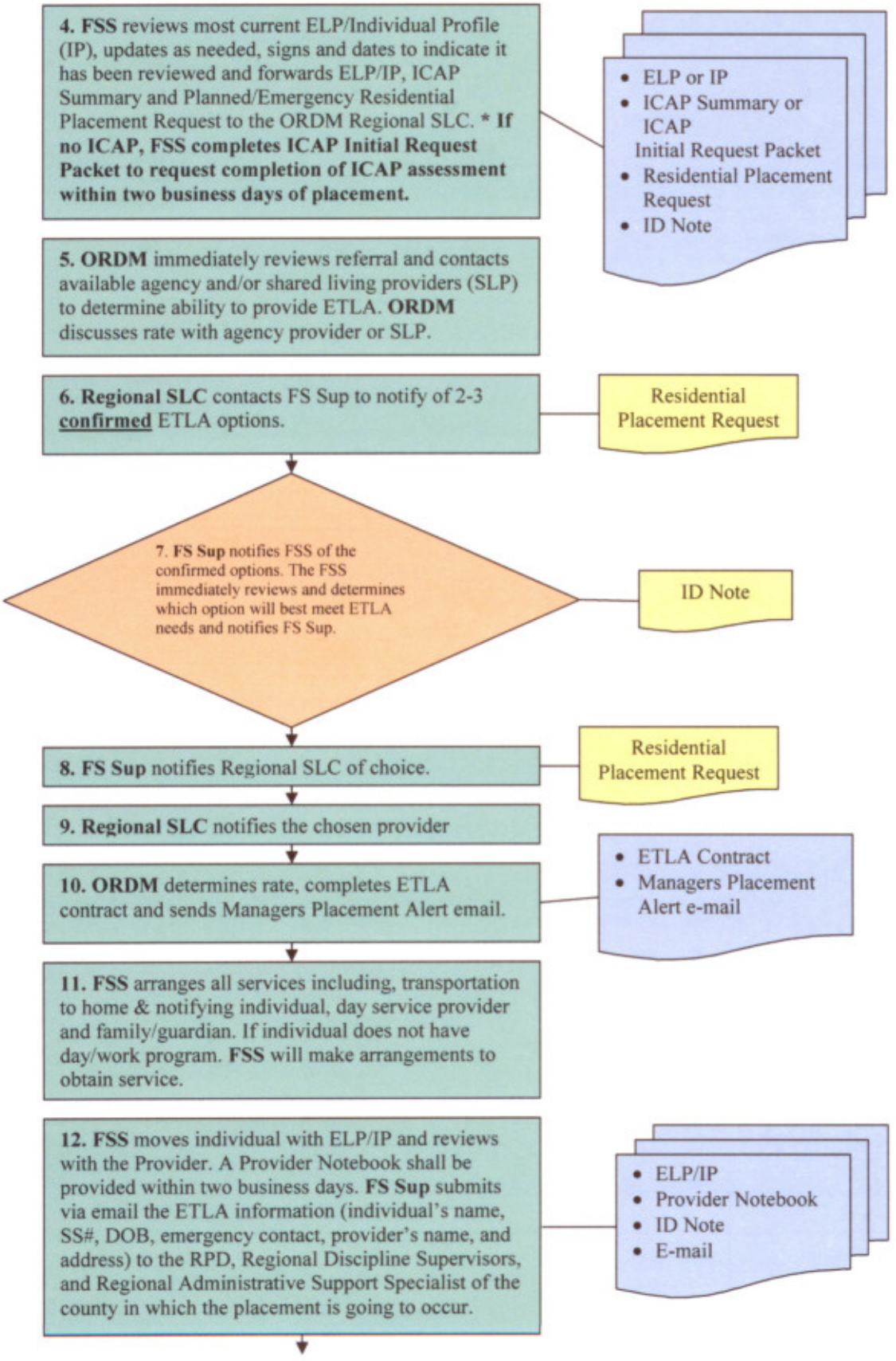

ETLA Needed (Residential)
1. Team member aware of ETLA need notifies other team members, Case Manager Supervisor (CM Sup) and Regional Program Director (RPD) to discuss alternative supports/options and/or need for referral to Office of Resource Development and
2. RPD or Designee notifies the ORDM Shared 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.
ELP
ICAP Summary
Residential Placement
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.
Residential Placement Request
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.
ID NOTE

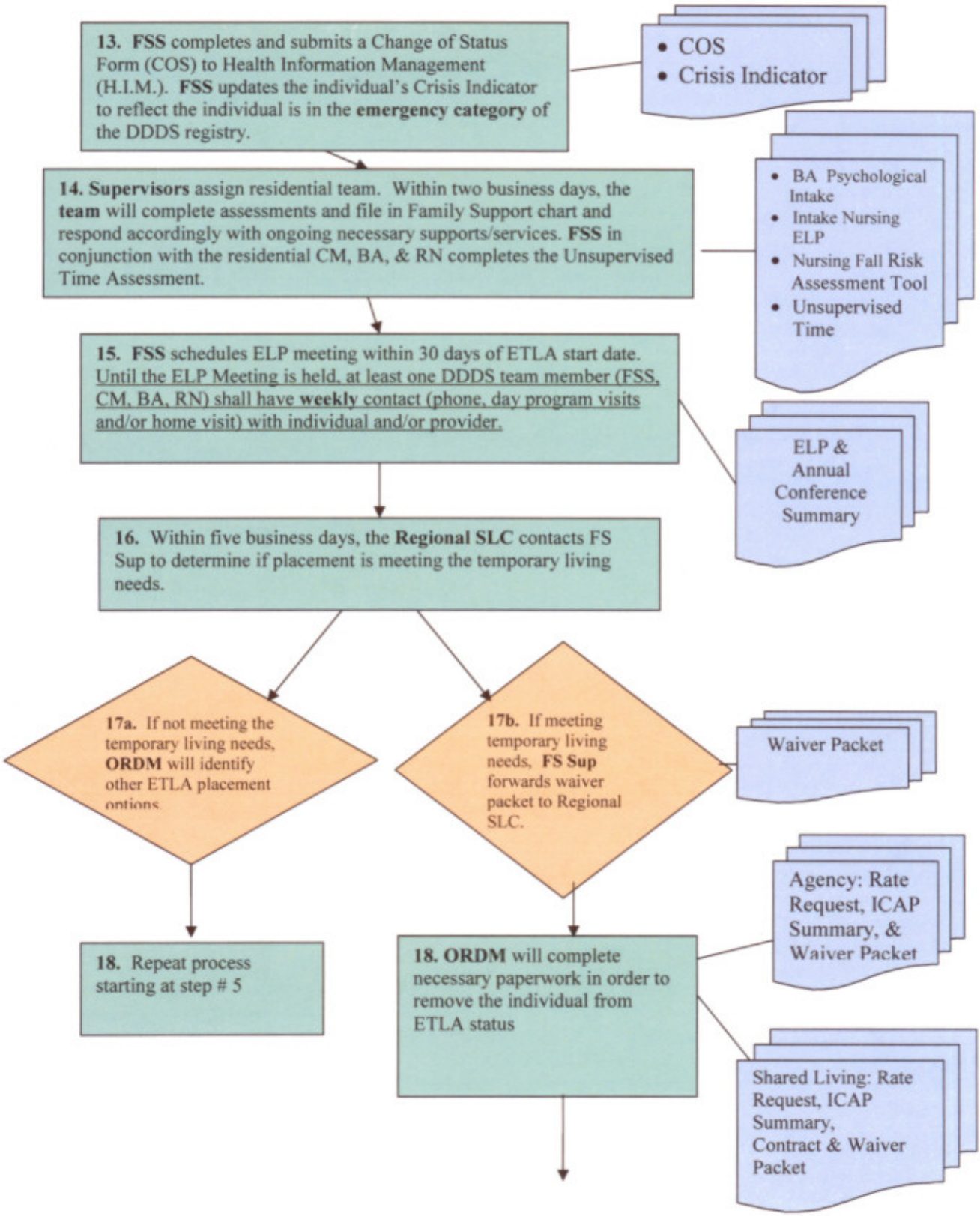

7. CM Sup notifies Regional SLC, RPD, BA Supervisor, and Nurse Supervisor of selected ETLA option.
7a. If individual is moving to another county, the Transferring RPD will notify the Receiving RPD.
8. Regional SLC notifies the chosen provider
9. ORDM determines rate, completes ETLA contract and sends Managers Placement Alert email.
ETLA Contract
Managers Placement Alert e-mail
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.
Provider Notebook for SLP
COR for Agency
ID Note
12. Transferring CM completes and submits a Change of Status (COS) to Health Information Management.
COS
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
ELP or ELP Review
Annual Conf. Summary

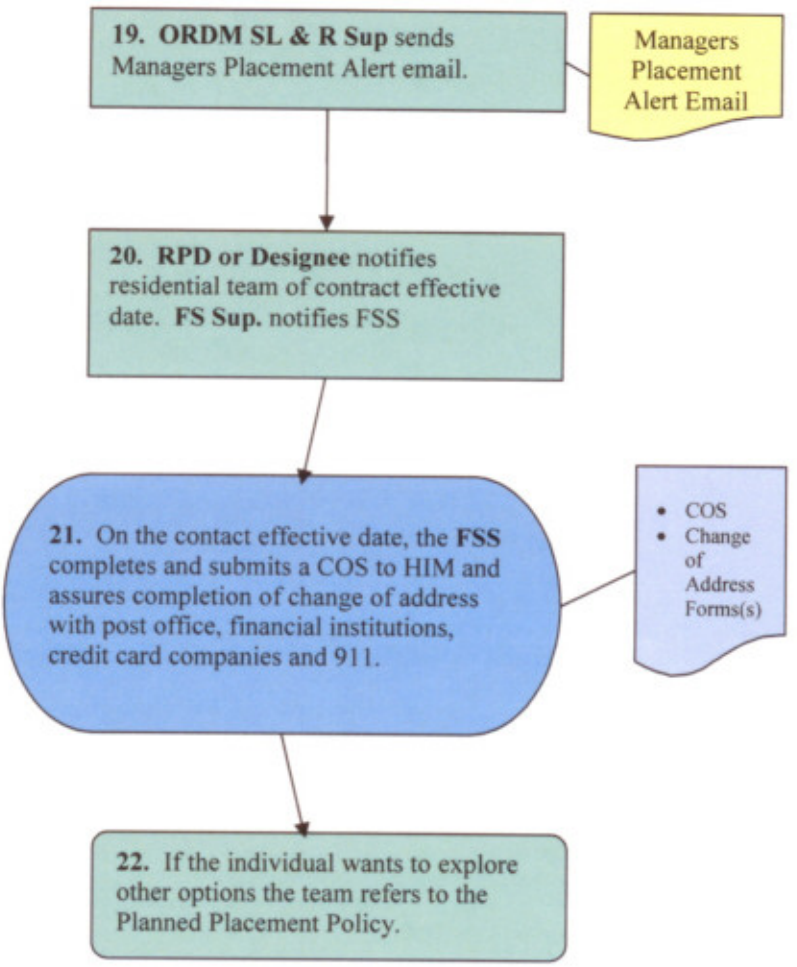

14. Within 5 business days, Regional SLC contacts CM Sup to determine if placement is meeting temporary living needs.
15a. If not meeting temporary living needs, ORDM will identify other ETLA placement options.
15b. If meeting temporary living needs, ORDM will complete necessary paperwork in order to remove the individual from ETLA status.
Agency: Rate Request & ICAP
Shared Living: Rate Request, ICAP Summary & Contract
16. Repeat process starting at step # 4
16. ORDM SL & R Sup sends Managers Placement Alert email.
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.
• COS
• Change of Address
19. If individual wants to explore other residential options, the team refers to Planned Placement Policy.

ETLA Needed- from Family Support/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.
• ELP or IP
• ICAP Summary or ICAP Initial Request Packet
• Residential Placement Request
• ID Note
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.
Residential Placement Request
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.
ID Note
8. FS Sup notifies Regional SLC of choice.
Residential Placement Request
9. Regional SLC notifies the chosen provider
10. ORDM determines rate, completes ETLA contract and sends Managers Placement Alert email.
• ETLA Contract
• Managers Placement Alert e-mail
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.
• ELP/IP
• Provider Notebook
• ID Note
• E-mail


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.
• COS
• Crisis Indicator
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.
• BA Psychological Intake
• Intake Nursing ELP
• Nursing Fall Risk Assessment Tool
• Unsupervised Time
15. FSS schedules ELP meeting within 30 days of ETLA 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.
ELP & Annual Conference Summary
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 ETLA placement options.
17b. If meeting temporary living needs, FS Sup forwards waiver packet to Regional SLC.
Waiver Packet
18. Repeat process starting at step # 5
18. ORDM will complete necessary paperwork in order to remove the individual from ETLA status
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 ELP~~
~~D.~~ DDDS Fall Risk Assessment Tool
~~E.~~ Agreement to Forward Benefit Check(s) Monies

Exhibits (cont)

E. Planned and Emergency Residential Placement Request
G. Intake Nursing ELP
H. Individual Profile
I. ICAP Initial Request Packet

EXHIBIT A

Flowchart Shapes Defined

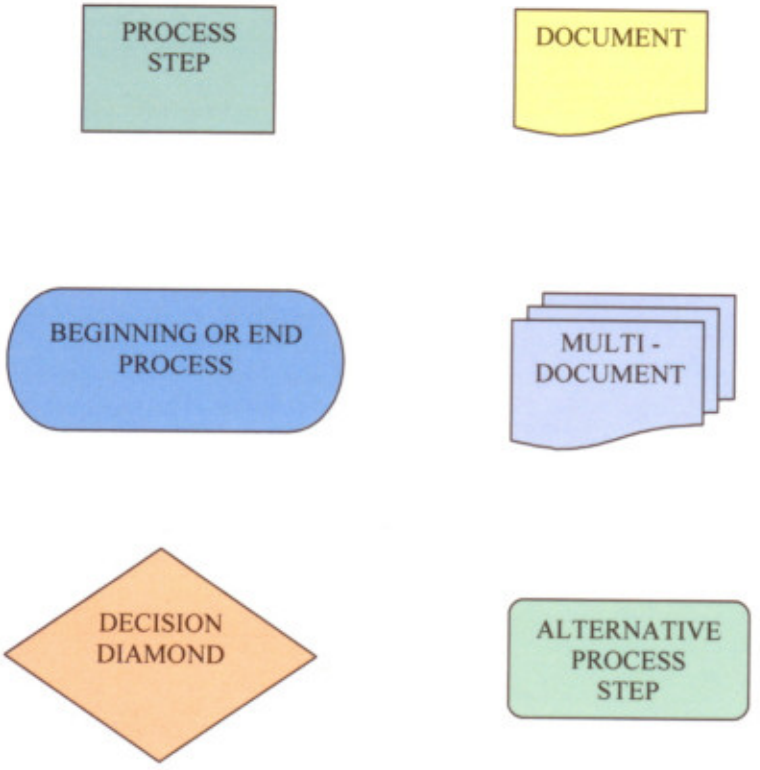


EXHIBIT B

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? _____

Psychological Intake (cont)

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: _____

EXHIBIT C

DDDS FALL RISK ASSESSMENT TOOL

Name of Person:_____ **MCI#:** _____

Person's Address: _____ **Person's DOB:** _____

_____ **Provider:** _____

_____

Circle appropriate response per category, then add total points

Points	0	1	2	3
Age	50 or below	51 to 60	61 to 69	70 or above
Mental Status	Oriented, cooperative		Oriented, uncooperative or depressed / agitated	Confused, not oriented
Physical Status	Well	Documented orthostasis	Dizziness, Vertigo, Syncope	Cachexia, Wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinent	Independent but incontinent; urgency / frequency
Sensory	No vision or hearing issues	Hearing loss only	Vision loss only	Hearing and Vision Loss
Neuromotor	No paralysis or spasticity	Upper extremity only	Lower extremity only	Both upper and lower
Gait	Unable to walk / stand (not at risk), or fully ambulated	Physically unable to walk / stand (but may attempt to)	Walks with help (e.g. mobility aids; cane, walker, holds onto furniture, etc.)	Balance problems – walking or standing; unsteady gait
Fall History, past 6 months	None	Near falls or fear of falling	Has fallen one or two times	Multiple falls (more than two)
Medications	None below	1 med below	2 meds below	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:**_____

PARC Approved 08/20/08
Form # 28/CS

EXHIBIT D

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF
DEVELOPMENTAL DISABILITIES SERVICES

DIRECTORS OFFICE

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*

EXHIBIT E

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

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES/ADULT SPECIAL POPULATIONS

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

Disease	**Yes**	**No**	**Not Sure**
Pertussis			
Measles			
Rubella			
Chicken Pox			
Other			

3. Immunizations

DPT/DT (circle one)	**Dates of Immunizations / Tests**	**Comments**
Polio		
Tetanus Toxoid		
Rubella		
Measles		
Mumps		
Influenza		
TB Testing		
Small Pox		
Other		

INTAKE NURSING ELP ASSESSMENT

Name _____

Current Physicians

Doctor, Address, Phone & Fax Number Specialty	Frequency of Visits	Date Last Seen

Current Medications

Current Medications	What It Is Used For . . .

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:

EXHIBIT G

	DELAWARE HEALTH AND SOCIAL SERVICES DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES	DIRECTORS OFFICE

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 _____ Oriental/Vietnamese

_____ Black/African American _____ 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

Please describe anything you have checked _____

_____

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: _____

Age and dates attended: _____

Were you a Special Education student? ☐ Yes ☐ No

Did you receive a Certificate of Attendance? ☐ Yes ☐ No If yes, what year? ____

Did you receive a diploma? ☐ Yes ☐ No If yes, what year? ____

Have you ever attended a day program? ☐ **Yes** ☐ **No**

If yes, what is the name of the program and when did you attend? _____

_____

5. TEST HISTORY

Date of your last psychological test? _____

Who tested you, and where? _____

6. WORK HISTORY

Where Have You Worked?	What Type of Work Did You Do?	When Did You Work There? (Dates)

7. **SERVICE HISTORY:** Do you or have you received services from any of the following **(please check all that apply)**

	Current	Past
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	☐	☐

Mental Hygiene Clinic/Mental Health Center	☐	☐
Location:		
Rockford Center	☐	☐
Stockley Center	☐	☐
Terry Center	☐	☐
Vocational Rehabilitation	☐	☐
Other:	☐	☐

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: Prescription or Non-Prescription
Reason Given: _____

How do you take it: _____

Medication: _____
Circle: Prescription 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*) _____

EXHIBIT H

ICAP Initial Request Packet

Please do not leave ay spaces blank. Write N/A if not applicable.

Individual		**Name of residential placement w/agency name**	
Date of Birth		**Name of day program placement w/agency name**	
Address (Street)		**Case Manager**	
Address (City, State, Zip)		**C.M. Phone # & e-mail address**	
Phone Numbers		**Parent/Surrogate/Guardian**	
Social Security #		**Phone #**	

Prescription Medication List (do not include dosage)	**Purpose of prescription medication (why was it prescribed?)**

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.

Name & Relationship	**Daytime contact phone number**

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.