The Arc of Monmouth

Participant's Name: _____

The Arc of Monmouth
1158 Wayside Road
Tinton Falls, NJ 07712

T (732) 493-1919
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www.arcofmonmouth.org

Achieve with us.

The Arc of Monmouth Intake Form

Name of Participant:			
Gender: ☐Male ☐Female		Date of Birth: / /	
Address:			
City	County	State	Zip
Participant's Cell Phone #:	Parent/Guardian Cell Phone #:		
Email:			
DDD ID #:	Tier Assignment: ☐A ☐B ☐C ☐D ☐E Were you assigned an Acuity Factor (Ex: Aa, Ba, Ea, etc.)? ☐Yes ☐No		
Support Coordination Agency Name:			
Support Coordinator Name: Support Coordinator email:	Support Coordinator Phone #:		

Are you enrolled in the DDD Supports Program? ☐Yes ☐No CCW? ☐Yes ☐No

Program interest; check all that apply :

- ☐Adult Services
- ☐Recreation
- ☐Work opportunity Center (WOC)
- ☐Residential
- ☐Other:_____
- ☐The Achievement Zone (TAZ)
- ☐College Experience (KACH)
- ☐Health Services
- ☐Family Support

For official use only:
Form received: _____(date)
Form evaluated: _____(date)
Notify Individual: _____(date)

Please return to: Kevin Maselli
Outreach Coordinator
kmaselli@arcofmomouth.org

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Participant's Name: _____

Medical Insurance Information:

Private Insurer ☐ Yes ☐ No *If yes, please complete below:*

Insurance Carrier:	Address:
Policy #:	Group #:

Medicaid ☐ Yes ☐ No *If yes, please complete below:*

Medicaid ID #_____

Medicare ☐ Yes ☐ No *If yes, please complete below:*

Medicare ID #_____

Legal Competency Status:

Please Note: At 18 all individuals reach the "legal age of majority". This means parents can no longer make decisions legally on behalf of an adult child, regardless of the nature of the individual's disability and regardless of whether or not the individual still lives with the family. Establishing guardianship is a legal process, and must be appointed by the courts.

☐ Is own guardian

☐ Has a legal guardian: Name of Legal Guardian: _____

☐ Has an appointed Guardian through Bureau of Guardianship Service: _____

Address: ☐ Same as home address or ☐ Other _____

Emergency Contact Information:

Participant's Primary Care Physician:	Phone #:
Physician's Address:	
Emergency Contact 1:	Relationship to Participant:
Cell Phone:	Alternate Phone:
Emergency Contact 2:	Relationship to Participant:
Cell Phone:	Alternate Phone:

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Participant's Name: _____

If Applicable, please provide Residential Provider name and Contact Information:

Residential Provider name: _____

Contact information: _____

Medical History

Are you in good health? ☐ Yes ☐ No

Has there been any change in your general health in the past year? ☐ Yes ☐ No

Seizures:	☐ Yes	☐ No	Explain:
Other Neurologic Conditions	☐ Yes	☐ No	Explain:
Diabetes:	☐ Yes	☐ No	Explain:
Cardiac Conditions:	☐ Yes	☐ No	Explain:
Choking:	☐ Yes	☐ No	Explain:
Asthma:	☐ Yes	☐ No	Explain:
Medical Allergies:	☐ Yes	☐ No	Explain/List:
Other Allergies:	☐ Yes	☐ No	Explain/List:

Do you have any other Medical Conditions? If yes please explain:_____

_____

_____

_____

Medications, Dosage, and Reason for Medication:

_____

_____

_____

_____

Medical or Physical Concerns/Restrictions (vision/speech/hearing/mobility):_____

_____

_____

_____

If needed, can you administer your own medication? ☐ Yes ☐ No

Are you capable of attending to your own hygiene? ☐ Yes ☐ No

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Transportation

If interested in attending one of our achievement centers please disregard, transportation is provided

Is a parent/guardian planning to drop you off in the morning? ☐ Yes ☐ No

Is a parent/guardian planning to pick you up at the end of the day? ☐ Yes ☐ No

Are you using an outside vendor for transportation services? ☐ Yes ☐ No

Transportation Vendor Company/Agency Name: _____

Behavioral History

Please note any behavioral/safety concerns we should be aware of, and suggestions of how you generally handle those concerns.

_____

_____

_____

_____

_____

_____

Is there any history of elopement? Will the individual run off or walk away from the group without telling someone and/or without permission? ☐ Yes ☐ No

Do you have a Behavioral Plan? If yes, please attach. ☐ Yes ☐ No

Please list any fears (ex: heights, water, animals) or areas of extreme sensitivity:

Please provide any other suggestions/comments that will help us best support the individual (availability, preferences, etc.).

_____

_____

_____

_____

_____

****Completion of this form does not guarantee admission to The Arc of Monmouth programs. We will reach out within 10 business days of receiving this completed form to inform you of next steps.**

Name of person completing this form (please print): _____

Signature of person completing this form: _____

Relationship to the Individual: ☐ Parent/Guardian ☐ Residential Manager ☐ Support Coordinator ☐ Other_____ Date: _____/_____/_____

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