Epilepsy Center of Northwest Ohio
New Client Collateral Packet

Hello! Thank you for your interest in The Epilepsy Center of Northwest Ohio. As we evaluate each new contract, there is a variety of information that we request to ensure that we can best meet your needs. Please keep in mind that comprehensive information helps us make an informed decision in our ability serve you. Omitting information may affect our ability to effectively serve you. All information submitted will be kept confidential.

If you have any questions about the information requested, please feel free to contact the Residential Manager at 419-867-5950. You may also contact your Service and Support Specialist for additional information as some may be in their files as well. All information should be returned to the Residential Manager at 5405 Southwyck Blvd, Toledo, Ohio 43614 or faxed to 419.867.5954.

For Pre-Admission Review:

- ☐ Copy of individual's current Individual Service Plan (ISP)
- ☐ Copy of current Behavior Support Plan (and past plans where available)
- ☐ Completed packet (as attached)
- ☐ List of past known medications where available
- ☐ List of any known legal problems, past or pending
- ☐ Copies of current skill development plans and report of current progress
- ☐ Copy of current level of care assessment (within 60 days)
- ☐ Current medical examinations completed within 30 day time period. Please refer to attached physical form.
- ☐ All immunizations current. Provide documentation.
- ☐ TB testing (2 step PPD test) will be current within 30 day time period.
- ☐ Dental exam must be current, within last 12 months.
- ☐ Psychological evaluation must be current within last year. Attach copy.
- ☐ Social evaluation must be current within last year. Attach copy.

Once you have been accepted as a client, we request the following information on your date of admission:

- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ State Identification Card
- ☐ List of all upcoming medical/counseling appointments, and a summary of all past appointments (preferably for the last year)
- ☐ List of appointments and the dates/months that they need to be scheduled in
- ☐ A comprehensive possessions inventory
- ☐ Medicaid and Medicare cards
- ☐ Life insurance, burial, and funeral policies where available
- ☐ A minimum 30 day supply of all medications

Date of application: ____________

Personal Information
Name of Applicant: __________________________

Address:____

Phone Number: ____________________ County of Residence: _____________

Date of Birth: ______________ Sex: ________ Religion: ___________________

Social Security # ___________________ Marital Status: __________________

Race: ______________ Hair Color: ______________ Eye Color: ___________

Height: ______________ Weight: ______________ Language: ____________

Name of SASS: ____

Supportive Relationships
Responsible Party: ___________________________ Relationship: __________

Address:____

Phone: Home: ___________________ Work: __________________________

Admission from: ____

Legal Guardian: ____

Address:____

Phone: __________________________

Emergency Contacts:
Name: _______________________________Relationship: _______________

Address:____

Phone: Home: ___________________ Work: __________________________

Name: _______________________________Relationship: _______________

Address:____

Phone: Home: ___________________ Work: __________________________

Family Contacts:
Name: _______________________________Relationship: _______________

Address:____

Phone: Home: ___________________ Work: __________________________

Name: _______________________________Relationship: _______________

Address:____

Phone: Home: ___________________ Work: __________________________

Medical Information

Diagnosis:

____

____

Past surgeries:

____

____

Medications/Treatments:

____

____

Special Medical Equipment:

____

____

Allergies:

____

____

Hospital of Choice:

____

Primary Care Physician:

Name: ______________________________ ___Phone: _____________________

Address:____

COMPLETE MEDICATION ADMINISTRATION ASSESSMENT (As attached)

Financial

________ SSI – Amount ________ ________ SSA – Amount ________

________ Waiver – Name ________ ________ Other ______________

Medicare # ________________________ Medicaid # _____________________

Insurance Information ____

Developmental Abilities

Ambulation

________ walks alone

________ walks with assistance

________ sits alone

________ sits with support in special chair

________ crawls/moves around floor

________ uses walker/crutches

________ uses wheelchair

________ able to climb stairs, indicate # _______

Eating

________ drinks independently
________ drinks from cup with assistance
________ eats independently with utensils
________ eats using fingers/hands
________ eats with assistance
________ needs to be fed
________ chews, eats regular food
________ needs special diet
________ fed by other than oral means

Toileting

________ uses bathroom independently
________ indicates need to use bathroom
________ incontinent – wears diapers
________ able to use bathroom during day
________ constipation is a problem
________ able to use bathroom during night
________ wipes independently
________ needs assistance with wiping
________ uses urinal/bedpan

Dressing

________ dresses independently
________ dresses with assistance
________ needs assistance with fasteners
________ needs complete assistance

Personal Hygiene

________ bathes/showers independently
________ brushes teeth independently
________ needs assistance with tooth brushing
________ needs assistance with bathing/showering

Communication

________ uses speech to communicate
________ uses some words/phrases
________ understands simple requests
________ gestures/vocalizes
________ uses a communication board/device
________ no effective communication

Sleeping

________ sleeps in bed with side rails
________ sleeps in bed
________ sleeps through night
________ does not sleep through the night

What supervision level does the applicant need in their own home in:

The kitchen ____

The living area ____

The bathroom ____

While sleeping ____

Behavior Concerns

Does the applicant have any of the following behavioral concerns?

________ Aggression
________ AWOL
________ Sexual deviance
________ self-injury
________ Other behavioral issues

If you marked any of the above, please explain the applicant's behavioral concerns, frequency, and intensity, we well as any interventions used.

____
____
____
____
____
____

Does the applicant have a behavior support plan in place? ________yes ________ no

Day Programming

Is the individual currently enrolled in day program/employment? _____yes ______no

Where? ____

Supervisor's Name: ____

Address:____

Phone: ____________________________ Fax: _________________________________

E-Mail Address: ____

Please note any additional information that you think would be helpful for us to know to provide services to the applicant.

____
____
____
____
____
____
____
____
____
____
____

Medication List

Client Name: ____

Medication Name	Dose	Route	Time(s) Administered	Prescribed By

Physician List

Client Name: ____

Doctor Name	Specialty	Address	Phone Number	Frequency of Visits

SELF-ADMINISTRATION ASSESSMENT

Individual: Date:

Name/Title of Person Conducting Assessment: Name/Title of Person Assisting with Assessment:

Person(s) conducting assessment will need to have all necessary information regarding current medications, including name, dose, route, time(s), why taking, and basic side effects.

Assessment Questions	Yes	No	Answer Based Upon
Able to identify medication(s)			
Able to indicate why he/she takes medication(s) [For example: for my seizures, my asthma, I get upset very easily]			
Correctly indicate dose of medication(s) [For example: 25mg, or 1 pill or 2 teaspoons, or 1 of these little cups to this line, etc.]			
Indicate health changes or when not feeling well [For example: taking a new pill and now my mouth is dry, my stomach hurts, etc.]			
Able to indicate what to do when meds low [For example: ask staff, go to drug store]			
Able to indicate what time to take medication(s) either by clock time or related to a specific routine in day (after breakfast, before bedtime)			
Is physically able to get medication(s) from storage, get medication(s) out of container and physically take/apply medication(s). If no, indicate what physical assist individual may need (note does not implicate mental alertness)			

- ☐ If individual can do 1-7, they should be considered independent in self-administration.
- ☐ If individual can do 1-5 but not 6 or 7 independently but need assistance, they can be considered self-administration with assistance. Once the assessment is completed, the service plan for the individual should include information concerning how medication administration will be done. Any of the following statements could be used in the service plan depending on what is correct for each specific person.
    - The individual can self-administer medication(s) without assistance.
    - The individual can self-administer medication(s) with assistance (select one of the following related to the assistance).
        - The individual receives assistance with self-administration of medication(s) through reminders of when to take the medication(s).
        - The individual receives assistance with self-administration of medication(s) through physically handing the medication container to them.
        - The individual is physically impaired and the provider may open the container for the individual to assist with self-administration.
        - The individual is physically impaired and the provider may open the medication container for the individual to assist with self-administration of medication.
        - The individual is physically impaired and the provider may physically assistance them with opening the medication containers and getting the medication to their mouth to prevent spilling, therefore assisting with self-administration of medication.
        - Other:
    - The individual cannot self-administer medication(s) with or without assistance.
    - The individual is not capable of self-administration of medication(s). IP Team should consider Skill Development programs as appropriate.

Physical Examination

Name ____ Date _____________ Age ________

2. Current Medication: Last MD Drug Review Date:

Medication Name	Dose	Route	Frequency

Examination

Pneumonia Vaccination (***Must be completed annually***) completed on: ____________________

Ht.: _______ Wt: ______ Wt change/Year: ___________ Diet: ______________________________

BP: ______________ TPR: _______________ Allergies: ______________________________________

General Appearance:

____

____

____

Vision:

____

Hearing:

____

Ear/Nose/Throat

____

Mouth

____

Neck/Chest

____

Heart

____

Lungs

____

Abdomen

Genitalia

Rectal/Pelvic

Extremities

Back

Neurological

Health Aids

Glasses

Hearing Aids

Other

Restriction of Activity:

Full Participation: ______________________Restricted Participation: ______________________

(Specify)

Past injuries, serious illnesses, recent surgery or recurring medical problems:

Medical Goals:

____

Physician Signature