OPTIONS Inc.

Thank you for considering the services of Options.

Enclosed you will find an application for services and related forms required for admission. You may need to review and sign the Release of Information forms to give permission for other people to forward information to us. If you need assistance understanding what the Release of Information form means, ask someone to help you. With this information, we will be able to proceed with your application and identify and develop an appropriate program plan for you.

Options will notify the referred person/legal representative within 30-days of receipt of a **completed** intake packet along with all required documentation of the admission decision. Reasons for denial of service request will be given along with potential alternative services. Options Inc. will maintain a written record of each application/referral for a period of four years.

If you have any questions or concerns regarding this intake packet, please contact:

Brenda Geldert
Executive Director
763.263.3684 Ext. 277
brendageldert@options-inc.org

OPTIONS, INC. APPLICATION FOR SERVICE

AS-002
Revised 10/23

Date: _____

I wish to apply to Options, Inc. for admission for: _____

Signature: _____ Title: _____
Case Manager, and/or Legal Guardian

The following **must** be completed prior to Application Review:

____Case Manager's statement of *Non-Duplication of Services*
____Consent for Release of Information
____Admission Form-Data Sheet and General Contacts
____Vocational and Living Skills Assessment
____Physical Examination Form
____Current Support Plan
____Psychological Evaluation

If eligible for services funding authorization will need to be secured before services will begin.

Options Use Only:

Date Received: _____
Reviewed by: _____
Referral Source: _____
Admission Meeting: _____

Options, Inc.
Non-Duplication of Services Statement

To the best knowledge of this case manager, the services provided to _____ by Options are not replacing services that are the statutory responsibility of a local education agency or that are otherwise available from a rehabilitation agency funded under Section 110 of the Rehabilitation Act of 1973, United Sates Code, Title 29, Section 730 as amended through October 31, 1986.

_____

Case Manager Signature Date

OPTIONS, INC. SPECIFIC RELEASE OF INFORMATION

DPF-008

MN Statutes, section 13.05, subdivision 4: Private or confidential data on an individual shall not be collected, stored, used, or disseminated by government entities for any purposes other than those stated to the individual at the time of collection in accordance with section 13.04, except as provided in this subdivision.

Date:

I, hereby, authorize:

(person(s) or agencies the data subject is authorizing to disclose information)

to disclose the information described below regarding:
(specific nature of the information to be disclosed)

which has been requested

(person(s) or entities to whom the subject is authorizing information to be disclosed)

Describe the requested information completely:

Describe the purpose(s) for which the information will be used, both at the time of the disclosure and at any time in the future:

I understand that only the information described above will be released, and that it will be used solely for the purpose described above. It will not be disclosed to any other source unless specifically authorized by me. I have been informed that I may refuse to authorize the release of this information and the consequences of such a refusal have been explained to me.

☐ This authorization will expire upon receipt of the information specified herein

or

☒ This authorization will remain in full force and effect subject to my right to revoke it at any time, until:

(date of termination; not to exceed one year)

I understand that I may revoke this authorization at any time and that I may review the information before authorizing its release, subject to my right to review this information under the controlling State and Federal law.

Person served and/or legal representative signature

Date

OPTIONS, INC. ADMISSION FORM AND DATA SHEET

DPF-003

Date Updated:	Options' standing orders Updated:
*This form is completed at service initiation and update as needed. Dated signatures are obtained at initiation and annually thereafter.	
PERSONAL INFORMATION	
Legal Name:	Date of birth:
Preferred Name:	Pronouns: He/Him She/Her
Guardianship type (self, private, public): Private	Language(s) spoken: English
Marital status: Single	Cultural/Religious consideration:
SERVICE INFORMATION	
Admission Date:	First Date of Service: Last Date of Service:
Day Support	
Prevoc	
Employment Group Support	
Exploration	
Development Plan	
Employment Support 1:1	
Transportation	
IDENTIFYING CHARACTERISTICS	
Gender:	Race:
Height:	Weight:
Hair color:	Eye color:
Communication Mode:	
Distinguishing characteristics/identifying marks:	
FINANCIAL INFORMATION	
Social Security Number (SSN):	Medical Assistance Number:
County of Residence:	PMI number:
County of financial responsibility (case mgmt):	Funding Source (waiver):
MEDICAL INFORMATION	
Diagnoses/History:	
Allergies (Drug, Food, Enviromental):	
Protocols (seizure, diabetic, Epi pen, etc.):	
Medical equipment, devices, or adaptive aides or technology used:	Specialized dietary needs:
Health Care Directive/DNR Protocol:	
MEDICATIONS/TREATMENTS	
IMMUNIZATIONS	
Tetanus:	Influenza:
Hepatitis B:	Pneumonia:
Mantoux:	Other:
HEALTH-RELATED CONTACT INFORMATION	
Name	**Address and telephone numbers**
Emergency Contact:	
Primary health care professional:	
Psychiatrist/Mental health professional:	
Other Mental health professional:	
Hospital of preference:	
Other health professional:	
Other health professional:	

GENERAL CONTACT INFORMATION		
	Name and Address	**Telephone Number/E-Mail**
Individual:		
Legal representative: Primary emergency contact:		
Residential contact:		
Case manager:		
Residential Director:		
Family member:		
Direct Deposit Email Address:		
Options Staff:		

OPTIONS, INC. EMERGENCY CALL LIST DPF-028

Name:

Date:

List in order of preference the individual who should be called in the event of the following. If it is the same, please indicate

EMERGENCY:

Name:	Phone:
Name:	Phone:
Name:	Phone:

ILLNESS:

Name:	Phone:
Name:	Phone:
Name:	Phone:

WEATHER CLOSING NOTIFICATION:

Name:	Phone:
Name:	Phone:
Name:	Phone:

When being transported home with Options, Inc.,
CAN be left at home without visual contact of a responsible party.

When being transported home with Options, Inc.,
CANNOT be left at home without visual contact of a responsible party.

Vocational and Independent Living Skills Assessment AS-005

Name:

Date:

In order to better understand the applicant's abilities, needs and to make initial plans for developing a service plan, we ask that you provide us with the following information:

Placement History

Please list prior programs and or employers, include their dates of attendance and type of services received.

Location	Dates From:	To:	Services

What are your current expectations for service areas for the applicant?

- ☐ Non-Vocational Day Supports
- ☐ Center Based Prevocational Work
- ☐ Community Crew Supports
- ☐ Independent Job Supports

Summary of Strenghts and Preferences

Social/community preferences:

Rituals/Routine:

Likes/Dislikes:

Strengths:

Important to individual:

Important for individual:

Preferred type of work if applicable (office, janitorial, industrial/assembly, food service, child care, etc.):

Independent Living Skills

Please provide a brief description of the applicant's abilities and needs, including your assessment of whether assistance and training would be appropriate in these areas.

Problem Solving (phone, time, numbers, reading, emergencies):

Personal Living Skills:

Eating:

Toilet Use:

General Appearance:

Physical Abilities:

Mobility:

Fine Motor:

Money Handling:

Street Safety & Transportation:

Communication and Learning Style

Preferred method of communication:

Receptive language skills and abilities:

Expressive language skills and abilities:

Techniques used for learning style:

Interpersonal & Emotional Skills

Has difficulty accepting direction from supervisors?

Does the applicant readily accept changes in routine?

Is the applicant distracted by the presence of others?

Does the applicant recognize/respect the personal space of others?

Does the applicant exhibit excessive dependency (constant requests for reassurance, approval, affection.)

Does the applicant exhibit unrealistic fears or feelings of persecution? Does applicant make false accusations towards others?

Does the applicant resist following instructions (refuses or does the opposite)?

Does the applicant takes advantage of/or manipulates others?

Does the applicant use inappropriate or obscene language or gestures when frustrated or upset?

Does the applicant require physical contact or instructional techniques used on an continuious basis to:
(Please indicate by checking each box that applies.)

☐ Calm or comfort a person by holding that person without resistance.

☐ Protect a person known to be at risk or injury due to frequent falls as a result of a medical condition. *(Such as a seizure disorder.)*

☐ Facilitate the completion of a task or response when the person does not resist or the resistance is minimal intensity or duration. This includes hand-over-hand training.

☐ Briefly block or redirect a person's limbs or body without holding the person or limiting movement to interrupt the person's behavior that may result in injury to self or others.

Please describe the contact or instructional technique identified above:

Has an Emergency Use of Manual Restraint *(EUMR)* been implemented with the applicant over the past year? If so, please describe.

Abuses or destroys property?

Has a history of or exhibits self-injurious behavior or Pica?

Has the applicant been physically aggressive towards staff or peers?

Does the applicant have a current Positive Support Transition Plan *(PSTP)* or have any other positive support programs that been a part of the applicant's Support Plan in the past year? If so, please describe briefly, including observations and effectiveness of these programs.

Sexuality Considerations

Does the individual have a history of sexually inappropriate contact with others?

Does the individual engage in sexually inappropriate comments or language?

Does the individual demonstrate a sexual pre-occupation with specific characteristics of an individual, object(s), or activity(s)?

Does the applicant have a history of exposing themselves to others? Self-stimulating behaviors in public? Disrobing in public?

ANNUAL PHYSICAL EXAMINATION DHF-001

8/14

Name:_____ Date: _____

Referred to (licensed health care professional): _____

DOB:_____ Allergies:_____ Diet:_____

Diagnoses:_____

_____

Current medications and doses: Purpose:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current treatments: Purpose:

_____ _____

_____ _____

_____ _____

_____ _____

Health concerns:_____

_____

_____

Are there any medical or psychological contraindications to the use of staff implemented manual restraint to protect this person, when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety? ☐ **Yes** ☐ **No**

If yes, what are they and are there any special adaptations or precautions staff may take to still use manual restraint in dangerous circumstances (list on next page)?

_____

EXAMINATION RESULTS:

The annual physical assessment is to include a physical examination and a review of the medical treatment plan.

Height:_____ Weight:_____ Ideal Weight Range:_____

Temp.:_____ Pulse:_____ Blood Pressure:_____

Review of Systems: Optional

Skin:_____ Lymph Nodes:_____

Eyes: (R)_____ (L)_____ Ears: (R)_____ (L)_____

Nose:_____ Throat:_____ Mouth:_____

Neck:_____ Lungs:_____

Heart:_____ Breasts:_____

Abdomen:_____ Extremities:_____

Genito-Urinary:_____ Ano-Rectal:_____

Posture:_____ Gait:_____

Nervous System:_____

Fine Motor:_____ Gross Motor:_____

Note any physical abnormality:_____

Vision Screening: Results:_____

Is a more thorough vision exam recommended? ☐ Yes ☐ No

Hearing Screening: Results:_____

Is a more thorough audiology exam recommended? ☐ Yes ☐ No

Note any problems with speech and language:_____

_____

Is referral to a speech/language therapist indicated? ☐ Yes ☐ No

Chest x-ray_____ or Mantoux given: _____ Location of Mantoux:_____
Date read:_____ Results:_____

Diphtheria-Tetanus shot given? ☐ Yes ☐ No Date of last Diphtheria-Tetanus shot: _____

I find this individual to be free of communicable disease: ☐ Yes ☐ No

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Summary of exam and diagnosis:_____

_____

_____

Treatment plan (new orders):_____

_____

Medications (new orders):_____

_____

Is individual capable of administering own medications? ☐ Yes ☐ No

Please Note:

1. All medications and treatments will be ordered for 1 year unless stop and start dates are indicated.
2. Your signature indicates you have reviewed these findings with the person/staff present.
3. Please provide instruction on when and to whom to report the following:
   a. Occurrence of adverse reactions to medications or treatments
   b. Medication not being administered or treatment performed as prescribed, whether by error of staff or refusal by the person
   c. Report to and when:

_____

_____

_____

_____

Physician signature: _____ Date: _____

Reviewed by: _____ Date: _____
Staff signature