ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

# PRE-SERVICE PROVIDER ORIENTATION

**INSTRUCTIONS:** This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services. A copy MUST be retained by the provider and a copy sent to the District Office. The provider must also ensure that a General Consent and Authorization form is completed and retained by the provider.

## PROVIDER INFORMATION

Provider's Name *(Last, First, M.I.)* ______________________________

Employer Tax No ______________ AHCCCS ID No ______________

Is there any special training required? Yes No Describe: ______________

Med Training Needed Yes No Seizure Management Training Needed Yes No

## CRITICAL INFORMATION

Individual's Name *(Last, First, M.I.)* ______________________________

Assists No. ______________ Birthdate ______________

Individual's Address *(No., Street)* ______________________________

City ______________ State ______ ZIP Code ______________

Guardian's/Responsible Party's Name *(Last, First, M.I.)* ______________________________

Relationship ______________ Phone Number ______________

Address *(No., Street)* ______________________________

City ______________ State ______ ZIP Code ______________

Emergency Contact's Name *(If other than responsible party)* ______________________________

Relationship ______________ Phone Number ______________

Support Coordinator's Name ______________________________

Office Location ______________ Phone Number ______________

Name of ALTCS/DDD Health Plan ______________________________

AHCCCS ID No. ______________ Phone Number ______________

Primary Care Physician's Name ______________ Phone Number ______________

Address *(No., Street)* ______________________________

City ______________ State ______ ZIP Code ______________

Urgent Care Facility's Name ______________ Phone Number ______________

Address *(No., Street)* ______________________________

City ______________ State ______ ZIP Code ______________

Other Health Insurance Information ______________________________

## DAY PROGRAM *(If applicable)*

Name of Day Program ______________ Program Type ______________

Days and Hours of Attendance ______________ Transportation Method ______________

Day Program Address *(No., Street)* ______________________________

City ______________ State ______ ZIP Code ______________

Phone Number ______________

See page 4 for EOE/ADA/LEP/GINA disclosures

## HEALTH-MEDICAL

### CURRENT MEDICATIONS AND SIGNIFICANT HISTORICAL ISSUES:

Med Log Required Yes No

Special Medication Instructions

**ALLERGIES TO:**

Food Yes No Specify ____________________

Medication Yes No Specify ____________________

Bee Stings Yes No Specify ____________________

Other Yes No Specify ____________________

Recommended Response to Allergic Reaction

____________________

**SEIZURES:**

Yes No Describe ____________________

Frequency ____________________ Approximate Duration ____________________

Recommended Response to Seizure Activity

____________________

**ASSISTIVE DEVICES:**

Vision ____________ Hearing ____________ Dental Appliances ____________

**PROTECTIVE DEVICES:**

Instructions for Use

Purpose ____________________

Other Individualized Health Care Routines

# PRE-SERVICE PROVIDER ORIENTATION

Individual's Name *(Last, First, M.I.)* ______________________________

Assists No. ______________________________ Birthdate ______________

## DIET

**FOOD:**

Independent with Utensils    Yes    No

Independent with Specific Utensils    Yes    No

Requires Limited Assistance    Yes    No

Requires Significant Assistance    Yes    No

Does Food Present A Choking Hazard    Yes    No

Required Consistency of Food    Normal    Chopped    Puréed

**SPECIAL DIET**

Tube Feeding *(Special instructions required)*    Yes    No ______________________________

Eating Disorder *(Describe)*    Yes    No ______________________________

**BEVERAGES:**

Independent with Any Cup/Glass    Yes    No

Independent with Adaptive    Yes    No

Requires Limited Assistance    Yes    No

Requires Significant Assistance    Yes    No

Independent in Obtaining/Requesting Beverages    Yes    No

Describe adaptive eating/drinking equipment ______________________________

Describe if Special Liquid Intake Needs ______________________________

System for Fluid Intake *(If applicable)* ______________________________

## COMMUNICATION

**COMMUNICATION SKILLS:** *(Check as applicable)*

Uses complex sentences    Uses simple sentences    Signs    Nods yes/no    Gestures

Describe Augmentative Communication Devices *(If applicable)* ______________________________

## MOBILITY

**BALANCE WHILE STANDING:**

Excellent *(not an issue)*    Moderate *(e.g.,stumbles)*    Poor *(e.g., very unsteady, falls)*

Utilizes Adaptive Aids for Balance    Yes    No

Independent Mobility *(Check as applicable)*

Crawling/Scooting    Kneeling    Standing    Walking    Running    Climbing

Mobility/Balance Aids *(Check as applicable)*

N/A    Walker    Cane    Crutches    AFOs    Leg Braces    Wheelchair    Running    Climbing

Other *(Specify)* ______________________________

Positioning Instructions ______________________________

Lifting/Carrying Instructions ______________________________

| PERSONAL CARE SKILLS *(Check all applicable items)* | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Dressing** | **Toileting** | **Bathing** | **Dental Care** | **Menses** | **Med. Admin** | **Other** |
| Independent | | | | | | | |
| Requires Prompting/Reminding | | | | | | | |
| Requires Limited Assistance/ Supervision | | | | | | | |
| Requires Significant Assistance | | | | | | | |
| IF APPLICABLE, DESCRIBE SPECIAL PERSONAL CARE NEEDS AND PREFERENCES | | | | | | | |

| BEHAVIORAL CONCERNS *(If applicable)* CIT Training Yes No | | |
|---|---|---|
| **BRIEF DESCRIPTION** | **APPROXIMATE FREQUENCY** | **RECOMMENDED INTERVENTION** |
| Aggression | | |
| Self-Injurious Behavior | | |
| Property Destruction | | |
| AWOL | | |
| Self-Stimulation | | |
| Sexual Acting Out | | |
| Other | | |

Is a Behavior Treatment Plan (BTP) Available for Additional Information Yes No

Reason for BTP ______________________________

Method Used to Obtain Information *(e.g., in person, case file)* ______________________________

**SIGNATURES**

Signature of Person Completing if Not Responsible Party ______________________________

Relationship ______________________________ Date ______________

Print Provider's Name ______________________________

Provider's Signature ______________________________ Date ______________

Print Responsible Person's/Guardian's Name ______________________________

Responsible Person's/Guardian's Signature ______________________________ Date ______________

Distribution: Copy – Provider; Copy – District Office; Copy – Parent/Guardian; Copy – Support Coordinator

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Disponible en español en línea o en la oficina local.