Inner Circle Communities • 1803 Bostwick Road • Columbus Ohio 43327
Office: (614) 725-3808 • Fax: (614) 725-2553
Email: info@innercirclecommunities.org • Website: www.InnerCircleCommunities.org

Intake Packet

Client Information		
Name:	**Date of Birth**	**Sex:**
Address:	**Home Phone:**	**Ethnicity**
City:	**State:**	**Zip:**
Referral Source:	**Phone**	**Country:**

Type of Waiver: ☐ Level 1 ☐ I.O Waiver Medicaid Identification #:_______________
Type of Service: ☐ Full-time ☐ Part-Time ☐ Saturday Only

Support Team			
MRDD Agency & Case Manager:	Phone:	Fax:	
Business Address:		Email:	
Provider Agency & Contact:	Phone:	Fax:	
Business Address:		Email:	
Emergency Contact:	Phone:	Cell:	Relation:
Address:		Email:	

General Information
Assessment of client?
Goals & objectives of Community H.O.P.E program?
Please discuss any reservations of client being successful in the Community H.O.P.E. Program?

Internal Use Only	
Admission Date:	**Start Date:**
Days/wk approved for program:	
Has client previously received like services? ☐ **Yes** ☐ **No**	

Inner Circle Communities is dedicated to providing the best possible services through compassion and understanding. We provide our clients with a positive environment that empowers independence, community awareness and opportunities for growth.

Inner Circle Communities • 1803 Bostwick Road • Columbus Ohio 43327
Office: (614) 725-3808 • Fax: (614) 725-2553
Email: info@innercirclecommunities.org • Website: www.InnerCircleCommunities.org

Emotional, Behavioral and Cognitive Functioning

SOCIAL

Assess the personality & social skills of the client:

☐ Extrovert, Social
☐ Well-Mannered
☐ Withdrawn
☐ Nervous, shy
☐ Forceful, Aggressive
☐ Joyful, happy
☐ Even tempered
☐ Other _____________

Describe interaction with peers:

☐ Significant # of peer relationships
☐ Difficulty making friends
☐ Trouble maintaining friendships
☐ Current/Past conflict with significant

Comments:

EMOTIONAL

Rank clients skills in the areas below on 1-5 scale
(5 being exceptional and 1 being poor)

☐ Command of Impulses
☐ Stress Management
☐ Decision Making
☐ Leadership (manages peer pressure)
☐ Embraces Change
☐ Conflict Resolution
☐ Anger Management
☐ Ability to process difficult emotions

Comments:

DEVELOPMENTAL AND PHYSICAL

Does client suffer from a hearing loss?
☐ Mild ☐ Moderate ☐ Severe ☐ None

Client independent in personal care needs?
☐ Yes ☐ No

Does client have any physical disabilities?

Describe any special accommodations needed:

COGNITIVE

What is cognitive diagnosis of client?
☐ Borderline ☐ Mild MR ☐ Moderate MR ☐ PDD ☐ Autistic

General description of reading and writing skills?

Client's preferred means of communication?
☐ Written only ☐ Verbal ☐ Sign Language
Other:

Clients level of signing?
☐ Home ☐ Basic ☐ ASL

Inner Circle Communities is dedicated to providing the best possible services through compassion and understanding. We provide our clients with a positive environment that empowers independence, community awareness and opportunities for growth.

Inner Circle Communities • 1803 Bostwick Road • Columbus Ohio 43327
Office: (614) 725-3808 • Fax: (614) 725-2553
Email: info@innercirclecommunities.org • Website: www.InnerCircleCommunities.org

LIFE SKILLS

Rank clients skills in the areas below on 1-5 scale
(5 being exceptional and 1 being poor)

- ☐ Independent Living
- ☐ Home making
- ☐ Personal care and hygiene
- ☐ Cleaning
- ☐ Purchasing home goods/shopping
- ☐ Financial management
- ☐ Transportation
- ☐ Use of community/public resources

Comments:

What are hobbies and interest of client?

BEHAVIOR

Has client ever been arrested, on probation or convicted of a crime? ☐ Yes ☐ No
Comments:

Any history of physical aggression towards others or property? ☐ Yes ☐ No
Comments:

Any history of sexual behaviors that may put others in harms way? ☐ Yes ☐ No
Comments:

General Health Information

Medication 1:	Dose and Time:	Purpose:
Medication 2:	Dose and Time:	Purpose:

Known Allergies? ☐ Yes ☐ No, if yes, explain

List any specific health concerns or special instructions?

Physician:	Phone:
Dentist:	Phone:
Psychiatrist:	Phone:

Inner Circle Communities is dedicated to providing the best possible services through compassion and understanding. We provide our clients with a positive environment that empowers independence, community awareness and opportunities for growth.

Inner Circle Communities • 1803 Bostwick Road • Columbus Ohio 43327
Office: (614) 725-3808 • Fax: (614) 725-2553
Email: info@innercirclecommunities.org • Website: www.InnerCircleCommunities.org

Consent Form

PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals to be called:

Physician ______________________________ Telephone ___________________

Dentist ______________________________ Telephone ___________________

Hospital ______________________________ Telephone ___________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) transfer of the child to any hospital that is reasonably accessible.

This consent does not cover major surgery unless the medical opinions of two additional licensed physicians or dentists, whom concur for such surgery, are obtained prior to the performance of such surgery.

Date ________________ Signature of Client____

Date ________________ Signature of Guardian______________________________________

PART II: REFUSAL OF CONSENT

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Advent authorities to take the following action(s):

Date ________________ Signature of Client ____

Date ________________ Signature of Guardian____

X_______ I consent to participating in all general activities of Community Hope, an Inner Circle Communities program.

I, ________________ hereby authorize Inner Circle Communities and its programs to use, reproduce and/or publish photographs and/or video that may pertain to me including my image, likeness and or voice as it relates to the program services. I understand that this material may be in various publications and press releases without first getting my written permission.

I, ________________ hereby give Inner Circle Communities and its programs permission to transport me in their own personal and/or agency vehicle as needed. I understand that all staff and those employed by the agency will have the State minimum liability insurance.

Date ________________ Signature of Client____

Date ________________ Signature of Guardian______________________________________

Inner Circle Communities • 1803 Bostwick Road • Columbus Ohio 43327
Office: (614) 725-3808 • Fax: (614) 725-2553
Email: info@innercirclecommunities.org • Website: www.InnerCircleCommunities.org

Consent to Release of Information

Client's Name __________________________________ DOB: __________ SSN: _____________

By signing this form, I(the above named client) am allowing Inner Circle Communities to release, exchange, receive information for the sole purpose of securing, coordinating and/or providing service delivery via: ☐ copies ☐ viewing ☐ verbal to the following (please identify all agencies and individuals)

Name of Person/Institution ____

Complete Mailing Address ____

Name of Person/Institution ____

Complete Mailing Address ____

Please indicate the reason for the release, and provide dates where possible:

☐ Continuity of Care ☐ Other (specify) ____

Check the information to be exchanged, released and or received:

☐ Assessments ☐ Incident Reports ☐ Summary of Services

☐ Contract(s) ☐ Other (specify) ____

This authorization is voluntary. I understand that I may cancel this consent at a later date by stating so in a written, signed and dated notification that is delivered to the Executive Director of Inner Circle Communities. If this consent is cancelled, I understand that information may have been released prior to the cancellation and is not a breach of confidentiality.

Inner Circle Communities does not require completion of this form as a condition of evaluation or treatment and refusal will not affect eligible benefits or services.

This agreement will expire 180 days from the date of signature, or as indicated unless cancelled by the client/guardian.

____ ______________________________
Signature of Client or Legal Guardian Date

____
Address, City, State, Zip Code

____ ____
Relationship, if not the Client Witness

Inner Circle Communities is dedicated to providing the best possible services through compassion and understanding. We provide our clients with a positive environment that empowers independence, community awareness and opportunities for growth.