**CONSUMER INFORMATION**

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| **INDIVIDUAL:** |  | **DATE:** |  |

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| **HOME PROVIDING SERVICES** | **PROVIDER INFORMATION** |
| Name:  Address:  City, ST Zip:  Phone:  Email: | Adult Care Housing, Inc.  1762 72nd Ave. NE  Saint Petersburg, FL 33702  Provider Number: 684228396  Service: Residential Habilitation |
| **INDIVIDUAL INFORMATION** | **INDIVIDUAL INFORMATION** |
| Name:  Address:  City, ST Zip:  Phone:  Email:  Region: | Social Security #:  Recipient ID:  Medicaid #:  Date of Birth:  Legal Status (competency):  Admission Date: |
| **GUARDIAN** | **PARENT/ EMERGENCY CONTACT** |
| Name:  Address:  City, ST Zip:  Phone:  Email:  Relationship: | Name:  Address:  City, ST Zip:  Phone:  Email:  Relationship: |
| **SUPPORT COORDINATOR** | **INDIVIDUAL’S EMPLOYER** |
| Name:  Agency:  Address:  City, ST Zip:  Phone:  Email: | Supervisor’s Name:  Company:  Address:  City, ST Zip:  Phone:  Email: |
| **BEHAVIOR ANALYST** | **DAY TIME ACTIVITY (SCHOOL, ADT, ETC.)** |
| Name:  Address:  City, ST Zip:  Phone:  Fax:  Email: | Name:  Address:  City, ST Zip:  Phone:  Fax:  Email: |

**PHYSICIAN INFORMATION**

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| --- | --- |
| **PRIMARY CARE PHYSICIAN** | **DENTIST** |
| Name:  Address:  City, ST Zip:  Phone:  Fax: | Name:  Address:  City, ST Zip:  Phone:  Fax: |
| **OTHER:** | **OTHER:** |
| Name:  Address:  City, ST Zip:  Phone:  Fax: | Name:  Address:  City, ST Zip:  Phone:  Fax: |

**MEDICAL INFORMATION**

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| **INDIVIDUAL:** |  | **DATE:** |  |

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| **DIAGNOSES:** |  |
| **ALLERGIES:** |  |

**MEDICATION**

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| **MEDICATION** | **DOSAGE** | **HOW OFTEN** | **PURPOSE** | **SIDE EFFECTS** | **CONTINUE** | **D/C** |
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**QUARTERLY/ ANNUAL PHYSICIAN VISITS (INCLUDE DENTAL, LABS, PSYCHIATRIST, ETC.)**

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| **DATE** | **PHYSICIAN** | **PHYSICIAN SPECIALTY** | **REASON** | **OUTCOME** |
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**NOTES**

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**QUARTERLY/ ANNUAL SUMMARY**

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| **INDIVIDUAL:** |  | **DATE:** |  |

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| **SUPPORT PLAN EFFECTIVE DATE:** |  |

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| 1st Quarter | 2nd Quarter | 3rd Quarter/ Annual\* | 4th Quarter |

*\* Annuals should contain a summary of all 3 quarters. Please also include Consumer Information Sheet and Medical Information Sheet with Quarterly.*

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| **SOCIAL SUMMARY**  (Include history, current status, community inclusion, day time activities, employment, friends, etc.) |
|  |
| **FUNCTIONAL SUMMARY**  (Identify skills or limitation in ADLs, communication, physical, cognitive, and community) |
|  |
| **MEDICAL SUMMARY**  (document health issues, permanent disabilities, medical diagnoses/prognoses, physician care, etc.) |
|  |
| **BEHAVIORAL SUMMARY**  (e.g. description of problem behaviors, estimated frequency/duration of problem behaviors, last occurrence of low frequency behaviors, description of severity/intensity/damage/impact to self/others/environment, extent to which behaviors result in harm or create a life-threatening situation, extent to which problem behaviors caused harm requiring documented medical care, behavioral observations, any hypothesis of function, interventions tried and their effectiveness. List of all major incidents, baker-acts, etc.) |
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| **SUMMARY OF PROGRESS TOWARDS GOALS**  (include progress of goals in the support plan, personal, behavioral, and long term) |
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| **WAS PROGRESS MADE ON GOALS?** | **YES:** |  | **NO:** |  |
| **WERE QUATERLY/ANNUAL GOALS MET?** | **YES:** |  | **NO:** |  |

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| **WILL THE GOALS CONTINUE?** | **YES:** |  | **NO:** |  | **NEW GOAL(S):** |

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| **CURRENT LEVEL OF RESIDENTIAL NEED:** |  |

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| **Individual Signature:** |  | | **Date:** |  |
| **Guardian Signature:** |  | | **Date:** |  |
| **Staff Signature:** |  | | **Date:** |  |
| **Date Sent To WSC:** |  | | **Method:** |  |
|  | |  | | |
| **Date Sent to Guardian:** |  | | **Method:** |  |
| ***Please include send receipt in chart.***  **Summary Reviewed and Given to Individual On:** | |  | | |