

Route to:

- All-Ways Care Plus (serves adults & children)
- Blue Water Developmental Housing (serves adults & children)
- CE Community Supports (serves adults only)
- Impact (serves adults only)
- Innovative (serves adults only)
- Spectrum Community Services (serves adults & children)

Date: _____

St. Clair County Community Mental Health Individual Profile

Case Number: _____ Age: _____ Male Female

H/SW B3 Children's Waiver

Address: _____ City: _____

Contact Person: _____ Program Site: _____

Phone Number: _____ Please respond no later than: _____

Support Services Requested:

Community Living Supports

Skill Building

Respite

Other: _____

NEEDS:

Personal Care:

	<u>Provide/Assist</u>	<u>Guide/Direct</u>	<u>N/A</u>
Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Briefing <input type="checkbox"/>			
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 Person <input type="checkbox"/>			
2 Person <input type="checkbox"/>			
Mechanical Lift <input type="checkbox"/>			
Ambulation/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adaptive Equipment: (i.e. wheelchair, walker, communication aid) _____

Consumer requires handicapped accessible transportation:

Yes No

This consumer is:

Verbal Non-Verbal
 Uses Sign Language Challenging Behavior Yes No

Is Behavior Plan in Place? Yes No

(Explain): _____

I would prefer my support worker be: Male Female Does not matter

Goal(s) to be implemented by the support worker, per the IPOS: (Use additional pages if necessary)

Goal: _____

Objective: _____

Intervention: _____

Number of hours/week authorized _____

Days of the week support required/Start & Stop Time:

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Staff Special Training Needs: _____