

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 <i>(Last, First, M.I.)</i>	EMPLOYER TAX NO.	AHCCCS ID NO.
IS THERE ANY SPECIAL TRAINING REQUIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:		
Med Training Needed <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Management Training Needed <input type="checkbox"/> Yes <input type="checkbox"/> No	

CRITICAL INFORMATION

INDIVIDUAL'S NAME <i>(Last, First, M.I.)</i>	ASSISTS NO.	BIRTHDATE
INDIVIDUAL'S ADDRESS <i>(No., Street, City, State, ZIP)</i>		
GUARDIAN/RESPONSIBLE PARTY'S NAME <i>(Last, First, M.I.)</i>	RELATIONSHIP	PHONE NO.
ADDRESS <i>(No., Street, City, State, ZIP)</i>		
EMERGENCY CONTACT'S NAME <i>(if other than responsible party)</i>	RELATIONSHIP	PHONE NO.
SUPPORT COORDINATOR'S NAME	OFFICE LOCATION	PHONE NO.
NAME OF ALTCS/DDD HEALTH PLAN	AHCCCS ID NO.	PHONE NO.
PRIMARY CARE PHYSICIAN'S NAME	PHONE NO.	
ADDRESS <i>(No., Street, City, State, ZIP)</i>		
URGENT CARE FACILITY'S NAME	PHONE NO.	
ADDRESS <i>(No., Street, City, State, ZIP)</i>		
OTHER HEALTH INSURANCE INFORMATION		

DAY PROGRAM *(If applicable)*

NAME OF DAY PROGRAM	PROGRAM TYPE	DAYS AND HOURS OF ATTENDANCE	TRANSPORTATION METHOD
DAY PROGRAM ADDRESS <i>(No., Street, City, State, ZIP)</i>			PHONE NO.

HEALTH – MEDICAL

CURRENT MEDICATIONS AND SIGNIFICANT HISTORICAL MEDICATION ISSUES:

MED LOG REQUIRED <input type="checkbox"/> Yes <input type="checkbox"/> No	SPECIAL MEDICATION INSTRUCTIONS
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ALLERGIES TO:

Food <input type="checkbox"/> Yes <input type="checkbox"/> No Specify	Medication <input type="checkbox"/> Yes <input type="checkbox"/> No Specify
Bee Stings <input type="checkbox"/> Yes <input type="checkbox"/> No Specify	Other <input type="checkbox"/> Yes <input type="checkbox"/> 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
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PROTECTIVE DEVICES:

INSTRUCTIONS FOR USE	PURPOSE
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OTHER INDIVIDUALIZED HEALTH CARE ROUTINES

PRE-SERVICE PROVIDER ORIENTATION

INDIVIDUAL'S NAME <i>(Last, First, M.I.)</i>	ASSISTS NO.	BIRTHDATE
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DIET

FOOD:

INDEPENDENT WITH UTENSILS <input type="checkbox"/> Yes <input type="checkbox"/> No	INDEPENDENT WITH SPECIFIC UTENSILS <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No
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DOES FOOD PRESENT A CHOKING HAZARD
 Yes No Required consistency of food Normal Chopped Puréed

SPECIAL DIET

TUBE FEEDING <i>(Special instructions required)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	EATING DISORDER <i>(Describe)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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BEVERAGES:

INDEPENDENT WITH ANY CUP/GLASS <input type="checkbox"/> Yes <input type="checkbox"/> No	INDEPENDENT WITH ADAPTIVE <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No
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INDEPENDENT IN OBTAINING/REQUESTING BEVERAGES
 Yes No Describe adaptive eating/drinking equipment

IF SPECIAL LIQUID INTAKE NEEDS DESCRIBE

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 *(stumbles, etc)* Poor *(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 Other *(Specify)*

POSITIONING INSTRUCTIONS LIFTING/CARRYING INSTRUCTIONS

PERSONAL CARE SKILLS *(Check all applicable items)*

	DRESSING	TOILETING	BATHING	DENTAL CARE	MENSES	MED. ADMIN.	OTHER
Independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires Prompting/reminding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires Limited assistance/ supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires significant assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 AVAILABLE FOR ADDITIONAL INFORMATION
 Yes No REASON FOR BTP

METHOD USED TO OBTAIN INFORMATION (In person, case file, etc)

SIGNATURES

SIGNATURE OF PERSON COMPLETING IF NOT RESPONSIBLE PARTY	RELATIONSHIP	DATE
PRINT PROVIDER'S NAME	PROVIDER'S SIGNATURE	DATE
PRINT RESPONSIBLE PERSON/GUARDIAN'S NAME	RESPONSIBLE PERSON/GUARDIAN'S SIGNATURE	DATE

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. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. 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.

**Stepping Stones Care L.L.C.
Waiver for In-Home Services**

By completing this form I allow for Provider,

_____, from Stepping Stones Care to provide in home and community services to the Member,

_____.

Stepping Stones Care LLC does not allow providers to bring clients into their own homes unless the home is certified and inspected by the State of Arizona. If the provider does decide to certify their home we require one year's employment to have certification. If you have documents or certification showing proof of home certification we will honor that one-year probation period with monitoring.

Guardian's Printed

Name _____ Date ____/____/____

Guardian's

Signature _____ Date ____/____/____

**Stepping Stones Care L.L.C.
Transportation Waiver**

Please complete the following form if you wish to receive transportation from your provider.

I, _____, give permission to

Guardian printed name

_____ from Stepping Stones Care L.L.C.

or other

Providers printed name

Designated staff, to transport _____ in an
DDD Member

authorized personal vehicle, company vehicle and or public transportation as Stepping Stones Care sees necessary and appropriate.

Guardian's Printed

Name _____ Date ____/____/____

Guardian's

Signature _____ Date ____/____/____