Family Together Alliance, LLC
Client Intake

Demographics:

Client Name: _____ DOB: _____ Age: _____ Gender: _____

Medicaid ID #: _____ Social Security #: _____

Nickname(s): _____ Phone #: _____

Address: _____

Parent/Guardian Name: _____ Phone #: _____

Address: _____

Parent/Guardian Name: _____ Phone #: _____

Address: _____

Are parents married? ☐ Yes ☐ No If not, whom has primary custody: _____

Does the client have an Authorized Representative? ☐ Yes ☐ No If yes, name and phone #: _____

What authorization does the Authorized Representative have? _____

Medical History:

Current Medical and/or Psychiatric Diagnoses (Include F Code, if known): _____

_____

_____

If diagnosis is Autism, please check the appropriate boxes:
Social Communication: • Level 1 (Requiring Support) • Level 2 (Requiring Substantial Support) • Level 3 (Requiring Very Substantial Support)
Restricted, Repetitive Behaviors: • Level 1 (Requiring Support) • Level 2 (Requiring Substantial Support) • Level 3 (Requiring Very Substantial Support)

If diagnosis is ADHD, please check the appropriate box: • Mild • Moderate • Severe

Medications *(including OTC, Vitamins, Supplements and Herbs)* / Include Dose and How Often Taken (For Example; XYZ; 20 MG; 2x/Daily)

_____

_____

_____

Does the client have a history of injuries / accident prone (*IE: concussions, fractures, stitches, etc):* _____

_____

_____

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Does the client have any food restrictions *(IE: food allergies, tactile issues that interfere with diet):* _____

_____

_____

Allergies: _____

_____

Does the client have any of the following medical concerns:

Seizures ☐ Yes ☐ No
GERD ☐ Yes ☐ No
Aspiration ☐ Yes ☐ No
Dehydration ☐ Yes ☐ No
Constipation/Bowel Obstruction ☐ Yes ☐ No
Wears Glasses/Contacts ☐ Yes ☐ No
Hearing Loss ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Chronic Cough ☐ Yes ☐ No
Frequent Ear Infections ☐ Yes ☐ No
Heart Issues ☐ Yes ☐ No
Fainting ☐ Yes ☐ No
Frequent Stomachaches ☐ Yes ☐ No

UTIs ☐ Yes ☐ No
Head Injuries/TBIs ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Eczema ☐ Yes ☐ No
ADD/ADHD ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Verbal Aggression ☐ Yes ☐ No
Physical Aggression ☐ Yes ☐ No
Sleep Difficulty ☐ Yes ☐ No
Speech Problems ☐ Yes ☐ No

If yes to any of the above, please provide details: _____

_____

_____

_____

_____

Any Other Concerns: _____

_____

_____

_____

Social History:

Who lives in home with client: _____

_____

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Are there pets in the home? If yes, please list: _____

Who does client spend time with (IE: sibling, particular peer/friend) and what activities do they do together? _____

_____

_____

What activities/hobbies does the client enjoy: _____

_____

_____

What music does the client enjoy? _____

Client Strengths: _____

_____

_____

Skills that would be beneficial for client to develop: _____

_____

_____

Safety in Home Setting:

Coping Skills client utilizes: _____

_____

_____

Weapons (guns, knives and all others) are locked in secured location and client does not have access • Yes • No
**Service/Care Provider will not be able to provide services in home where weapons are not secured*

Medications, including over the counter, are placed out of reach of client.

Trigger items are placed out of reach of client. Trigger items for client include: _____

_____

_____

Contact Information for Emergencies:

Name of Parent/Guardian: _____ Phone #: _____

Name of Parent/Guardian: _____ Phone #: _____

Name of Additional Support Person/Relationship: _____ Phone #: _____

Family Together Alliance, LLC
PO Box 1441, Castle Rock, CO 80104
720.310.8462

Client's Rights:

As a client receiving services from Family Together Alliance, LLC or its subcontractors, I have the following rights:

1) To have a Service Plan developed and to receive a copy of the Service Plan.

2) To have appropriate dental and medical services including the right to be free of unnecessary medications.

3) To be protected from Mistreatment, Abuse, Neglect and Exploitation (MANE).

4) To be allowed the right to practice the religious belief of his/her choice and protection from pressure to participate in any religious practices not desired.
   a) No client shall be required to perform any act or be subject to any procedure whatsoever, which is contrary to his/her religious belief.

5) To have the opportunity to communicate freely and privately with persons of his/her choosing.

6) To be ensured the opportunity to vote, if eligible, including information on the responsibilities of citizenship and assistance to exercise this right.

7) To have their record kept confidential and reviewed by client at their request.

8) To possess and use his/her own clothing and personal belongings.

9) To have access to food of their choice/preference at all times.

10) To have access to all common areas of the day/work setting, or in their home.

11) To be able to come and go as they choose.

12) To be able to have visitors of their choosing at any time.

13) To only shared with persons with legal authority, or by written consent of client.

14) To manage his/her own financial affairs, unless contraindicated in SP.

15) To establish and participate in a committee that represents my interests and attempts to influence agency policies.

16) To access the Board of Directors of the local Community Center Board and will not be discriminated against for advocating on their behalf.

17) To read and/or have explained to them any rules and regulations of HCPF, Developmental Disabilities Services or the local Community Center Board pertaining to their activities, programs, and services. In addition to this summary of rights and how to exercise them each client will receive a summary of rights and a description of how to exercise them at initiation of services and any time changes are made in the description of their rights. A description of his/her rights will be reviewed with each client annually, or at their request.

18) To appoint an authorized representative to represent their interests.

19) No client shall be discriminated against because of race, gender, color, national origin, religion, disability, or because he/she has received services or supports under any provision of CRS 25.5-10 as amended.

20) To decline to participate in research.

21) To fair labor practices and not required to perform labor.

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Family Together Alliance, LLC Grievance Process for Clients/Parents/Guardians and/or Authorized Representative:

1) Complete form below

2) If you desire anonymity, please leave name and demographic information blank

3) Please note, if choosing to remain anonymous, grievance/complaint will be managed internally only

4) Alternate Agencies to assist with grievances/complaints include:

   a) Mediation Project: 888.815.6684
   b) The ARC of Colorado: 303.864.9334
   c) Colorado Department of Health Care Financing: 303.866.2993
   d) Disability Law Colorado: www.disabilitylawco.org 800.288.1376

5) You may also wish to contact your CCB

6) Family Together Alliance, LLC will reach out to you in regards to your grievance/complaint within 10 business days to discuss in more detail

7) Family Together Alliance, LLC will provide resolution to your grievance/complaint within 30 business days of filing with Family Together Alliance, LLC Secretary