ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PRE-SERVICE PROVIDER ORIENTATION

Last Date Updated/Reviewed: _____ Reviewer: _____

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 and updated annually thereafter. A copy MUST be retained by the provider and a copy sent to the Support Coordinator to save to the Member's File.

MEMBER INFORMATION

Individual's Name *(Last, First, M.I.)*: _____

Assists No.: _____ Birthdate: _____

Gender/Identity: _____ Language Preference: _____

Cultural Preference(s): _____

Qualifying Diagnosis: _____ Other Diagnosis(s): _____

Individual's Address *(No., Street,City, State, ZIP Code)*: _____

Electronic Visit Verification (EVV) Device Preference Use: _____

Does the Member have an Advanced Directive: ☐ Yes ☐ No Does the Member Smoke: ☐ Yes ☐ No

Does the Member Drink Alcoholic Beverages: ☐ Yes ☐ No

SPECIALIZED TRAINING

Medication Administration Training Needed: ☐ Yes ☐ No Seizure Management Training Needed: ☐ Yes ☐ No

Feeding Training Needed: ☐ Yes ☐ No Prevention & Support Training Needed: ☐ Yes ☐ No

Behavior Plan Training Needed: ☐ Yes ☐ No Mobility/Transferring Training Needed: ☐ Yes ☐ No

Mobility Training Needed: ☐ Yes ☐ No

Is there any additional specialized training required? ☐ Yes ☐ No If yes, Describe: _____

GUARDIAN/RESPONSIBLE PERSON INFORMATION

Guardian's/Responsible Person's Name *(Last, First, M.I.)*: _____

Relationship: _____ Phone Number: _____

Language Preference: _____ Email Address: _____

Cultural Preference(s): _____

Address *(No., Street,City, State, ZIP Code)*: _____

Emergency Contact's Name *(If other than responsible party)*: _____

Relationship: _____ Phone Number: _____

MEDICAL/BEHAVIOR HEALTH CONTACT INFORMATION

Name of ALTCS/DDD Health Plan: _____

AHCCCS ID No.: _____ Phone Number _____

Other Health Insurance Information: _____

Primary Care Physician's Name: _____ Phone Number _____

Address *(No., Street,City, State, ZIP Code)*: _____

Pharmacy: _____ Pharmacy Number: _____

Address *(No., Street,City, State, ZIP Code)*: _____

Behavioral Health Provider: _____ Behavior Health Phone: _____

Urgent Care Facility's Name: _____ Phone Number: _____

Address *(No., Street,City, State, ZIP Code)*: _____

See page 6 for EOE/ADA disclosures

SUPPORT COORDINATION CONTACT INFORMATION

Support Coordinator's Name:

Office Location: Phone Number:

Support Coordinator Supervisor:

Support Coordinator Supervisor Phone:

Support Coordinator Supervisor Email:

HEALTH-MEDICAL

CURRENT MEDICATIONS AND SUPPORT NEEDS:

Medication Log Required: ☐ Yes ☐ No

Where can a list of current medication and any special instructions be found?

ALLERGIES TO:

Food: ☐ Yes ☐ No Specify:

Medication: ☐ Yes ☐ No Specify:

Bee Stings: ☐ Yes ☐ No Specify:

Other: ☐ Yes ☐ No Specify:

Required Response to Allergic Reaction, provide any written orders for Health Care Professional:

SEIZURES:

☐ Yes ☐ No If yes, Describe what type of seizure and what they look like:

Frequency: Approximate Duration:

Required Response to Seizure Activity, provide any written orders for Health Care Professional:

Nursing Services Required: ☐ Yes ☐ No

ASSISTIVE DEVICES: ☐ Yes ☐ No

Vision: Hearing: Dental Appliances:

Other Individualized Health Care Routines:

NUTRITION

EATING *(CHECK ALL APPLICABLE ITEMS)*

	Utensils	Food Prep	Bringing Food to Mouth	Choking	Menses	Understands Temperature of Food	Other
Independent, no support required	☐	☐	☐	☐	☐	☐	☐
Prompting/Reminding Required	☐	☐	☐	☐	☐	☐	☐
Limited Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐	☐
Significant Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐	☐

Describe Any Special Dietary Requirements Including Food Consistency, Temperature, Calorie Needs or Write NA:

DRINKING *(CHECK ALL APPLICABLE ITEMS)*

	Ability to Use Cup or Glass	Ability to Use Adaptive Cup or Glass	Able to Obtain or Request Beverages	Understands Temperature of Beverages	Choking	Other (Describe Below)
Independent, no support required	☐	☐	☐	☐	☐	☐
Prompting/Reminding Required	☐	☐	☐	☐	☐	☐
Limited Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐
Significant Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐

Describe Any Adaptive Drinking Equipment/Special Liquid Intake Needs/System for Fluid Intake or Write NA:

SPECIAL DIET

Intake of Food via the Gastrointestinal (GI) Tract: ☐ Yes ☐ No

(Special instructions required / check type and include special instructions)

☐ Nasogastric Tube (NGT) _____

☐ Orogastric Tube (OGT) _____

☐ Nasoenteric Tube _____

☐ Oroenteric Tube _____

☐ Gastrostomy Tube _____

☐ Jejunostomy Tube _____

Who will provide training by when? _____

Eating Disorder *(Describe type and support needed)*: ☐ Yes ☐ No _____

Other Dietary Restrictions *(Describe)*: ☐ Yes ☐ No _____

COMMUNICATION *(CHECK ALL APPLICABLE ITEMS)*						
	Uses Complex Sentences	**Uses Simple Sentences**	**American Sign Language**	**Nods Yes/No**	**Gestures/ Signs**	**Other (Describe Below)**
Independent, no support required	☐	☐	☐	☐	☐	☐
Prompting/Reminding Required	☐	☐	☐	☐	☐	☐
Limited Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐
Significant Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐

Describe Any Other Communication Requirements or Write NA:

Describe Augmentative Communication Device or Write NA:

MOBILITY *(CHECK ALL APPLICABLE ITEMS)*							
	Crawling/ Scooting	**Kneeling**	**Standing**	**Walking**	**Running**	**Climbing**	**Other (Describe Below)**
Independent, no support required	☐	☐	☐	☐	☐	☐	☐
Prompting/Reminding Required	☐	☐	☐	☐	☐	☐	☐
Limited Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐	☐
Maximum Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐	☐

Describe Any Other Mobility Requirements or Write NA:

For any devices, who will provide the training and by when? _____

MOBILITY/BALANCE AIDS ***(Check as applicable)***

☐ N/A ☐ Walker ☐ Cane ☐ Crutches ☐ AFOs ☐ Leg Braces ☐ Manual Wheelchair

☐ Power Wheelchair ☐ Other (Specify): _____

TRANSFER SUPPORT NEEDED: ☐ Yes ☐ No If yes, height: _____ Weight: _____

☐ One-Person Lift ☐ Two-Person Lift ☐ Mechanical Lift ☐ Lift/Transfer Less than 50 lbs

☐ Lift/Transfer More than 50 lbs ☐ Slide Board

Lifting/Carrying Instructions: _____

Positioning Instructions: _____

TRANSPORTATION SUPPORT NEEDED:

☐ Car Seat ☐ Adaptive Vehicle Required ☐ Other Transportation Needs _____

PERSONAL CARE *(CHECK ALL APPLICABLE ITEMS)*							
	Dressing	**Toileting**	**Bathing**	**Oral Hygiene**	**Menses (if applicable)**	**Med. Admin**	**Other (Describe Below)**
Independent, no support required	☐	☐	☐	☐	☐	☐	☐
Prompting/Reminding Required	☐	☐	☐	☐	☐	☐	☐
Limited Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐	☐
Maximum Assistance/ Supervision Required	☐	☐	☐	☐	☐	☐	☐

Describe Special Personal Care Needs and Preferences or Write NA:

BEHAVIOR *(If applicable)* ☐ Yes ☐ No		
Brief Description	**Approximate Frequency**	**Recommended Intervention**
Verbal Aggression		
Physical Aggression		
Self-Injurious Behavior		
Property Destruction		
Member Leaves Area w/o Informing Anyone		
Self-Stimulation		
Sexual Acting Out		
Crisis Intervention/Hospitalization within last 6 months		
Extreme Liquid/Food Seeking		
Ingesting Non-Edible Objects		
Difficulty with Transitions		
Difficulty Understanding consequences		
Substance Abuse – Drug, Alcohol, Other		
Other		

Is a Behavior Treatment Plan (BTP) Available for Additional Information ☐ Yes ☐ No

Reason for BTP _____

Method Used to Obtain Information *(e.g., in person, case file)* _____

Is there a Functional Behavior Assessment (FBA) Available for Additional Information: ☐ Yes ☐ No

Is there a Crisis Intervention Plan Available for Additional Information: ☐ Yes ☐ No

Is there additional Behavior Health Support provided through the Health Plan: Yes No

Where is the additional information saved *(e.g., in person, case file)*:

PROTECTIVE DEVICES: Yes No

Prescription on File: Yes No PRC Approval Date:

Instructions for Use:

Purpose:

EMPLOYMENT/DAY PROGRAM *(If applicable)*

Name of Employment Day Program: Program Type:

Days and Hours of Attendance: Transportation Method:

Day Program Address *(No., Street,City, State, ZIP Code)*:

Phone Number: Are there any special staffing needs:

PROVIDER INFORMATION

Provider's Name *(Last, First, M.I.)*:

Qualified Vendor:

Qualified Vendor Address:

Emergency Contact: After Hours Phone Number:

SIGNATURES

Signature of Person Completing if Not Responsible Party:

Relationship: Date:

Print Provider's Name:

Provider's Signature: Date:

Print Responsible Person's/Guardian's Name:

Responsible Person's/Guardian's Signature: Date:

Distribution: Copy – Provider; Copy – District Office; Copy – Parent/Guardian; Copy – Support Coordinator