Residential Transition Survey January 2024

To be completed by Sunrise Caring Association Parent / Guardian / Social Worker

Name: _____

Sunrise Client Name: _____ age: ☐ under 20 ☐ under 30 ☐ under 45

☐ 45 and older

So we can gain a little more insight into our current membership, please complete this survey and return it as soon as possible by email to together@sunrisecaringassociation.com or by paper to The Sunrise Adult Training Centre C/O Kim Voaden.

Throughout this survey, "Client" reflects the person who is enrolled in Sunrise Adult Training Centre Programs. Please complete one survey for each individual Client in your care.

1. In what areas does this Client have the greatest needs? *Rank 5-0. 5 being greatest need, 0 indicating little to no need .*

___ Employment skills needed for gainful employment
___ Basic academic skills (reading, writing, arithmetic)
___ Household chores (cleaning, laundry, etc.)
___ Community safety
___ Communication skills (ability to express oneself to others)
___ Substance Abuse education
___ Decision making/ goal setting/problem-solving skills
___ Friendships and social relationships
___ Meal planning, preparation, & cleaning up
___ Money management skills
___ Personal care needs (grooming, shaving, dressing skills etc.)
___ Disability knowledge/self-advocacy
___ Recreational/leisure skills
___ Safe sexual behavior and sexual health education
___ Shopping skills (comparison shopping, handling money, etc.)
___ Assistive technology
___ Travel skills (pedestrian, public &/or private transportation)
___ Vocational and career exploration (opportunities to experience and learn about several different types of careers and/or jobs)
___ Health care management
___ Toileting
___ Other: _____

Place a check mark beside your answer(s)

2. Five years from today where do you wish this Client to live

☐ At home with parents
☐ With family – other than parents
☐ In an apartment/home on their own
☐ In an apartment/home with roommate(s)
☐ In a day time supported independent living program with their own room in a home
☐ In a day time supported independent living program with roommate(s)
☐ In a group home with 24/7 onsite care provider
☐ Other: _____

3. Concerns that you have about your son/daughter living on his/her own include:

☐ Can't shop independently
☐ Can't manage money
☐ Health related concerns
☐ Has been too dependent
☐ Won't take good care of self (eating, hygiene, etc)
☐ Will be lonely
☐ Will be exploited (sexual, physical, financial)
☐ Will not take medications as prescribed
☐ Will be drawn to illegal drug use
☐ Will be drawn to crime
☐ Other: _____

Guardianship / Financial Supports / Trusts (To be discussed at our May meeting)

4. How do you anticipate this Client would be financially supported? *(check all that apply)*:

□ NAU
□ Other Family Support
□ Individual Formal Trust
□ His/her own wages
□ Your financial support
□ Other: _____
□ I don't know

5. Do you think that your client could be their own legal guardian? ☐ **YES** ☐ **NO**

Do they :

☐ Need a guardian/conservator for financial decisions
☐ Need a guardian/conservator for medical decisions
☐ Need an advocate or personal representative for day to day decisions
☐ Need a medical proxy
☐ Need Power of Attorney
☐ Need a legal guardian appointed
☐ Not sure/don't know

6. Have you or any other interested care provider prepared (a trust fund/a special needs trust/a managed investment account) for the future support of this Client? ☐ **YES** ☐ **NO**

7. Have you prepared a will that includes plans for your Client? ☐ **YES** ☐ **NO**

8. Do you think your Client will achieve/ do they have a driver's license? ☐ **YES** ☐ **NO**

Rank by 0-5 (5 being most often.)

9. Does your client **travel** by:
_____Bicycle
_____Walk
_____Public Transportation
_____His/her own car
_____Taxi
____Get rides in the family car or with friends
_____Other: _____

10. **Bank Account**
Do you expect that your client:
would have their own bank account? ☐ **YES** ☐ **NO**
would have access to a debit or credit card and the skills to use it? ☐ **YES** ☐ **NO**
would understand a bank statement? ☐ **YES** ☐ **NO**

11. **Food**
Does your client:
-know how to shop for groceries and household items independently? ☐ **YES** ☐ **NO**
-do any meal planning and grocery list creation? ☐ **YES** ☐ **NO**
-know how to store foods correctly? ☐ **YES** ☐ **NO**
-clean food preparation surfaces and equipment / dishes safely? ☐ **YES** ☐ **NO**
-benefit from food purchase and prep assistance:
- ☐ for each meal and snack,
- ☐ daily,
- ☐ weekly,
- ☐ no need

-travel to and transport groceries from the store on their own? ☐ **YES** ☐ **NO**

12. **Household maintenance**

-Is your client able to shop for clothing and household items on their own? ☐ **YES** ☐ **NO**
-Are they able to travel to and transport purchases from the store? ☐ **YES** ☐ **NO**
-Is your client able to independently keep their own room clean and tidy? ☐ **YES** ☐ **NO**
-Can they keep their clothing in good clean condition? (place in drawer or on hanger by themselves) ☐ **YES** ☐ **NO**
-Are they able to keep shared living spaces clean and tidy? ☐ **YES** ☐ **NO**
-Can the client recognize household maintenance issues and call for help? (plumber/ electrician/carpenter etc) ☐ **YES** ☐ **NO**

13. **Medical upkeep**.
-Would this client be able to make appointments for themselves for doctors, dentists, eye specialist and therapists? ☐ **YES** ☐ **NO**
-Would this client know to ask for assistance from a PSW (Personal Support Worker) or Social Worker if they were in need of a medical or similar assistance? ☐ **YES** ☐ **NO**
-Would this client need an advocate to assist in defining their issue(s) and determining what sort of help they needed? ☐ **YES** ☐ **NO**
-Would they need assistance in preparing for such appointments? (Being ready, getting there on time, transportation to and from)? ☐ **YES** ☐ **NO**
-Once at an appointment would they need a person to speak on their behalf to explain their situation☐ **YES** ☐ **NO**
-Would they need someone to help them understand any procedures being done or suggested or needed? ☐ **YES** ☐ **NO**
-Is this client able to consent to a procedure? ☐ **YES** ☐ **NO**
-Is this client the only one technically authorized to give consent at the moment (no legal medical guardian) ☐ **YES** ☐ **NO**

Check answer(s)
14. Who would you want to help with medical upkeep decisions and to follow through on suggested hygiene, PT, OT and pharmaceutical drug management?
☐ The Client
☐ You
☐ Other family member of the Client
☐ Residential staff person / Personal Support Worker
☐ Government Nurse
☐ Court appointed Legal guardian

15. If you were not available at all, how dependent would you expect this Client to be on someone else to meet their day to day needs? Would they need to be in contact with someone

☐ Constantly

☐ Hourly
☐ Daily
☐ Weekly
☐ Monthly

16. This client is involved in:
□ Recreational activities that he/she does alone
□ Integrated activities (team members with and without disabilities)
□ Classes (to develop hobbies, and explore areas of interest)
□ Sports as a team member
□ Sport as an individual
□ Art Classes (ie dance, painting music)
□ Mindfulness sessions
□ Other: _____ _____

17. In the next 5 years, this client will probably:
(check all that apply)
☐ Do Activities with friends
☐ Make Friends with disabilities
☐ Make Friends without disabilities
☐ Join Organized recreational activities (clubs, team sports)
☐ Get married
☐ Have children
☐ Have a boy/girlfriend, but no marriage
☐ Have very little romantic or social contact with a boy/girlfriend
☐ Have a committed relationship/life partner