C·E·R·T·S

Collaborative Effort to Reinforce Transition Success

A Day Program for Adults with Multiple, Severe Disabilities
PRELIMINARY INTEREST FORM

All information is considered confidential

Today's Date: ___________________

Prospect's Name ____
Last First Middle

Address: ____

Date of Birth: ____________________________________ Gender: _______ Height _______ Weight _________

Person Filling Out Application: ____
Name Relationship to Prospect

Contact/Mother/Guardian's Name: ____

Contact/Father/Guardian's Name: ____

Contact Phone #: ________________________________ Email Address: _______________________________

Where does Prospect live? (Ex. with family, in group home, shared living, etc.) ________________________________

Nature of Prospect's Disability

Diagnoses: Primary: ____

Secondary: ____

Age at onset of disability: _____ Does Prospect use feeding tube? Y___ N___, Have seizure disorder? Y__ N___

Any behavior issues? Y___ N ___ If yes, please describe____

Is prospect weight bearing? Y___ N___, Continent? Y__ N___, Need Oxygen? Y__ N__, Ambulatory? Y__ N___

DDDS Status

Eligible for DDDS services? Y___ N___ In Process____ ICAP Assessment done? Y___ N___ In Process_____

DDDS Case Worker Name: ____________________________ Email/Phone: ____________________________

Has legal guardianship been obtained? Y___ N___ If yes, what type: Legal______ Medical ________

Is prospect in school? Y ___ N____ If yes, which one & when graduating? ______________________________

Is prospect currently attending an adult program? Y ____ N ___ If yes, which one & why looking to change?

____

When does prospect wish to begin attending a day program? ____