IPOP: Residential Information

Profile Information

Individual Name*: _____ Provider/Program Name: _____

Create Date*: _____ Entered By*: _____ Title: _____

Emergency Evacuation at Home

Recognizes Alarm? ☐ Yes ☐ No

Comments _____

_____

_____

Assistance Needed for Evacuation ☐ None ☐ Verbal ☐ Physical ☐ Other

Comments _____

_____

_____

Can the individual dial 911? ☐ Yes ☐ No

If yes, can the individual relay pertinent information to the 911 dispatcher? ☐ Yes ☐ No

Behavioral Concerns Comments _____

_____

_____

Behavioral concerns related to evacuation? ☐ Yes ☐ No

Comments _____

_____

_____

Personal Hygiene

Individual's ability to complete personal hygiene tasks/type of assistance required _____

_____

_____

Monitoring Required? ☐ Yes ☐ No

If yes, Reason for Monitoring ☐ Safety ☐ Concern ☐ Privacy ☐ Completion of Tasks ☐ Other

Comments _____

_____

_____

Adaptive Equipment Required? ☐ Yes ☐ No

If yes, Indicate how it is used _____

_____

_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

Money Management

Individual's ability to use money: ☐ Independently Handle ☐ Handling Limit ☐ Assistance from family ☐ Assistance from representative payee ☐ Total assistance with money management ☐ Work on budgeting ☐ Difficulty with judgment/vulnerability

Comments _____

_____

_____

Actions taken to safeguard _____

_____

_____

Daily Living Skills

Able to select appropriate clothing? ☐ Yes ☐ No

Assistance Required _____

_____

_____

Able to dress self? ☐ Yes ☐ No

Assistance Required _____

_____

_____

Able to complete laundry tasks? ☐ Yes ☐ No

Assistance Required _____

_____

_____

Able to complete household tasks? ☐ Yes ☐ No

Assistance Required _____

_____

_____

Able to utilize appliances? ☐ Yes ☐ No

Assistance Required _____

_____

_____

Supervision in the Community

☐ Lives independently

☐ As determined by family ☐ Independent traveler ☐ Within visual range on outings

☐ One-on-one supervision ☐ Arms-length ☐ Route traveler

If route traveler, indicate approved route(s) of travel _____

_____

_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

Comments _____

_____

_____

Specialized Instructions ☐ Visual Range ☐ Special checks ☐ Lives in the community

Specify Frequency _____

_____

_____

Supervision and assistance required for use of restrooms (note reason for supervision) _____

_____

_____

Supervision in the Home

☐ Lives independently, section not applicable

Able to stay home alone? ☐ Yes ☐ No ☐ As determined by family

Specify time _____

_____

_____

Specialized Instructions: ☐ Visual Range ☐ Special checks ☐ Arms-length ☐ One-on-one supervision ☐ As determined by family ☐ Independent within the home with staff present ☐ Other

Comments _____

_____

_____

If special checks, specify frequency _____

_____

_____

Sexual consent status ☐ Consenting ☐ Non-consenting

Bed checks? ☐ Yes ☐ No ☐ Lives in community

If yes, indicate frequency _____

_____

_____

Specify concerns/supervision needs when outside in yard or on deck _____

Supervision during transportation _____

_____

_____

Other Significant Information

Comments _____

_____

_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)