R.O.O.C., Inc.
Intake Questionnaire

Name: _____ ☐Male ☐Female ☐Married ☐Single
Last First Middle Initial

Address: _____ _____
Street City State Zip County

This is ☐ my own home/apt. ☐ a family home ☐ an AFC/licensed home (name) _____

Phone: (____)_____ Date of Birth: ___/___/___ Social Security Number: _____

Legal Guardian: ☐ Under age 18 ☐ Own ☐ Court Appointed (Please provide court document)

Guardian Name: _____ Phone number: _____

Address: _____

Referring Agency: _____

Funding Source: _____

Tell us about yourself:

What are things you like to do? _____

_____

What are some things you are good at? _____

_____

_____

What do other people like about you? _____

_____

_____

Have you ever participated in a program like ROOC before? ☐Yes ☐No If yes, what was the program and what did you do there? _____

_____

What do you want ROOC to help you do? _____

_____

What are things you do not like? _____

_____

What are the most important things we should know about you? _____

_____

Is there anything else we should know that will help us provide services to meet your needs? _____

_____

Who are the people you count on to help you make decisions? _____

MEDICAL INFORMATION

Who do we call in case of an emergency? _____ Phone _____

Who is your doctor? _____ Phone _____

Doctor's address: _____

What is your primary disability? _____

Do you take medication? ☐ Yes ☐ No If yes, please fill out the following chart:

Medication	Dosage	Purpose	Taken at ROOC or Worksite (Yes or No)

****If you will take any medication at ROOC, please complete a medication control form and attach to the packet.**

Do you take medication by yourself? ☐ Yes ☐ No Do you need help with medication? ☐ Yes ☐ No

Do you have seizures? ☐ Yes ☐ No If yes, please describe: _____

Date of last seizure: ____/___/___ Approximate frequency: _____

Do you have allergies? ☐ Yes ☐ No If yes, please describe:_____

Do you have asthma? ☐ Yes ☐ No If yes, please describe: _____

Do you have any dietary restrictions? ☐ Yes ☐ No If yes, please describe: _____

Do you use any adaptive equipment? ☐ Yes ☐ No If yes, please describe: _____

Do you have any other special medical needs? _____

_____

TRANSPORTATION INFORMATION

How will you get to ROOC? ☐Public Bus ☐Home Transport ☐Own ☐ Other _____

Is there an alternate drop off address? ☐ Yes ☐ No (if yes, list) _____

Who lives there and when should we use this address? _____

_____

EDUCATION INFORMATION

Level of Education Attained: ☐ Still in school ☐ Diploma ☐ G.E.D. ☐ Certificate ☐ Other

Name of School: _____

Last Date Attended: ___/___/___ City, State, Zip: _____

EMPLOYMENT HISTORY

Dates From	To	Name and Address of Employer	Title	Duties	Reason for Leaving

Are you interested in community-based work? ☐ Yes ☐ No If yes, describe your dream job: _____

_____

What supports will you need to work? _____

_____

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OFFICE USE ONLY

Intake Packet Received: ___/___/___ Authorized: ___/___/___ Start Date: ___/___/___

	Program(s)	Date	Manager(s)		Program(s)	Date	Manager(s)
1				**2**			
3				**4**			
5				**6**			
7				**8**			
9				**10**			

Packet Contents

☐ Confidentiality and Disclosure

☐ Emergency Medical Authorization

☐ Consent for Services

☐ Medication Control Form

☐ Acknowledgement of Rights/Problem Solving

☐ Federal W-4

☐ Michigan W-4

☐ New Hire Reporting Form

☐ Payroll Authorization

☐ Notice of Privacy Practices Acknowledgement

☐ I-9 Form and copies of required documents List: _____

Program Manager Signature and Date: _____

Executive Director Signature and Date: _____