ACHaD Department 2021-2022 Intake Form

Date _____

Which of the following best describes the age of the participant:

❒ Child/Teen

❒ Adult 21+

Name of Participant_____ Birth Date _____

Address_____

City_____State_____Zip _____

Participant's Phone # _____Email_____

Religious Identification ❒ Jewish ❒ Other _____ Gender _____

Participants requiring 1:1 assistance will be responsible for providing their own 1:1 aide

Participant will be accompanied by a 1:1 aide: ❒ Yes ❒ No

Emergency Contact Information

Name of Parent(s)/Guardian_____

Parent(s)/Guardian Address _____

City_____State_____Zip _____

Email_____ Cell Phone #_____

Home Phone # _____ Work/Other Phone # _____

Name of Emergency Contact and/or Caregiver (if different than above) _____

Address_____

City_____State_____Zip _____

Email_____ Cell Phone #_____

Home Phone # _____ Work Phone # _____

CHILD/TEEN SECTION (adults please write N/A on first line)

School Attending _____ Classroom Size _____

Grade Entering in 2019 _____ IEP: ❒ Yes ❒ No 504: ❒ Yes ❒ No

Check all that apply:

❒ Access to aide ❒ Inclusive Classroom

❒ 1:1 Educational Assistant ❒ Resource Room

❒ Self-Contained Classroom

Was Extended School year recommended for your child/teen? ❒ Yes ❒ No

Related services and supports (in and outside of school) i.e. OT, PT, Speech, etc.

_____

Residential Facility Information (if living at home, please write N/A on first line)

Name of Facility _____

Facility Address _____

City _____ State _____ ZIP Code _____

Name of Contact Person/Program Manager _____

Contact Email _____ Contact Phone # _____

Medical/physical restrictions? ❒ Yes ❒ No

❒ Asthma ❒ Hearing Loss ❒ Diabetes ❒ Visual Impairment ❒ Seizures ❒ Other

Check all that apply and explain any additional health concerns/restrictions:

_____

_____

Allergies: (medications, food, bee stings, etc.) ❒ Yes ❒ No

If yes, please identify specific allergy/reaction:

_____

_____

Are you taking any medications? ❒ Yes ❒ No

If yes, please list:_____

_____

Are you able to wait independently for transportation home? ❒ Yes ❒ No

What is his/her disability/classification?

_____

_____

Please indicate nature of disability (please provide details)

_____

_____

Please describe developmental/intellectual strengths and challenges:

_____

_____

_____

Communication:

Ability to communicate verbally:	❒ good	❒ fair	❒ poor
Responds to simple instructions:	❒ good	❒ fair	❒ poor
Communicates using gestures:	❒ good	❒ fair	❒ poor
Listens and follows directions:	❒ good	❒ fair	❒ poor
Uses sign language:	❒ good	❒ fair	❒ poor
Attention span:	❒ good	❒ fair	❒ poor
Hearing:	❒ good	❒ fair	❒ poor
Vision:	❒ good	❒ fair	❒ poor

Please explain:_____

_____

Mobility/Motor Skills:

Ambulation:	❒ good	❒ fair	❒ poor
Body Balance:	❒ good	❒ fair	❒ poor
Control of hands/fine motor skills:	❒ good	❒ fair	❒ poor
General physical ability:	❒ good	❒ fair	❒ poor
Independent bathroom skills:	❒ good	❒ fair	❒ poor

Please explain:_____

_____

Social Functioning:

Ability to interact with others:	❒ good	❒ fair	❒ poor
Ability to share and take turns:	❒ good	❒ fair	❒ poor
Ability to follow directions:	❒ good	❒ fair	❒ poor
Ability to stay with a group:	❒ good	❒ fair	❒ poor
Ability to transition:	❒ good	❒ fair	❒ poor

Please explain:_____

_____

Behavior triggers

What makes your child/adult upset, angry, anxious, or overwhelmed? *Check all that apply*

❒ Being touched

❒ Loud noises

❒ Entering their personal spaces

❒ Transitions

❒ Other (please be specific) _____

_____

Warning signs

What are some warning signs your child/adult exhibits when frustrated or in distress?

Check all that apply

- ❒ Throwing objects
- ❒ Crying
- ❒ Yelling
- ❒ Running
- ❒ Swearing
- ❒ Hurting Self
- ❒ Hurting others
- ❒ Pacing
- ❒ Other (please be specific) _____

_____

Calming Strategies

What is helpful for your child/adult to calm down? *Check all that apply*

- ❒ Reading a book
- ❒ Squeeze ball
- ❒ Walking/pacing
- ❒ Listening to music
- ❒ Deep Pressure
- ❒ Other (please be specific) _____

_____

_____

Please describe any behavioral programs used at home, in a residential setting or in an employment setting _____

_____

_____

Please indicate specific techniques for motivation, re-direction or maintaining focus: _____

_____

Please offer suggestions for easy transitioning or changes in routine:

_____

_____

Please describe any sensory challenges: _____

_____

What are your expectations from this program? _____

_____

_____

Please include any additional information that would be helpful in working with your child/teen/adult:

_____

_____

_____

_____

Member's Signature_____ Date_____

Parent(s) Signature_____ Date_____

The ACHaD Department looks forward to working with you. Please return the form to:

Nina Staiman, Associate Director, Adult and Inclusion Department
Betty and Milton Katz Jewish Community Center
1301 Springdale Road, Cherry Hill, New Jersey 08003
(856) 424-4444 ext. 1204, email: nstaiman@jfedsnj.org

ACHaD

Achieving Community Hopes and Dreams

Special Needs Department of the Katz JCC