

## **STEP – ADULT TRAINING SERVICES**

### **Referral Information Requirements**

Thank you for your interest in attending STEP - Adult Training Services. In order for STEP to process your application for enrollment, please submit the following referral information:

*Please complete the enclosed form:*

- o Application for Enrollment

*Please submit along with your application for enrollment:*

- o Current IPP (*Regional Center*)
- o Current IEP (*If Applicable*)
- o Current Psychological Evaluation
- o Current Social Summary (*Regional Center*)

Upon notification of acceptance to STEP, and prior to enrollment:

*Please complete the following:*

- o STEP Program Agreement
- o Completed Physician's Report for Community Care Facilities (*LIC 602*)
- o Conservatorship Documentation (*If Applicable*)

**STEP ADULT TRAINING SERVICES**

**Application for Enrollment**

Application Date: \_\_\_\_\_

**I. CLIENT PROFILE**

Client Name: \_\_\_\_\_ Gender: \_ Date of Birth: \_\_\_\_\_

Residential Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Language Spoken / Understood: \_\_\_\_\_

Legal Competency Status: \_\_\_\_\_

Regional Center Service Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Mother: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_

Father: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_

Legal Guardian / Conservator: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**II. EMERGENCY INFORMATION**

Persons to notify in the event of an emergency (list at least 2):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Other Significant Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Additional Emergency Medical Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **III. HISTORICAL INFORMATION**

Previous Residence Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Previous Residence Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Previous Day Program Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Previous Day Program Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Work History: \_\_\_\_\_

### **IV. MEDICAL**

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Medical History: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

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Mobility Equipment (wheelchair, walker, orthopedics, etc.): \_\_\_\_\_

Postural Supports required for maintaining proper position and body alignment for health and / or therapeutic program participation (*Identify with a check mark*):

Seat Belt: \_\_\_\_\_ Abductor: \_\_\_\_\_

Chest Support: \_\_\_\_\_ Lap Tray: \_\_\_\_\_

Lateral Support: \_\_\_\_\_ Arm Supports: \_\_\_\_\_

Head Support: \_\_\_\_\_ Foot Plates: \_\_\_\_\_

Other: \_\_\_\_\_

**HEALTH SERVICES:** STEP provides limited medical services, per individual client needs, under Title 22 Incidental Medical Regulations. STEP is NOT a Health Licensed Medical Facility and does NOT provide all of the services listed below. Certain health conditions may preclude applicant from being accepted into program. List **ALL** services needed. If the client will need the service during program hours (**9:00AM-3:00PM**), **check yes or no**.

Enteral Feeding & Hydration via gastrostomy and / or jejunostomy    \_\_\_ yes \_\_\_ no

Medication Administration    \_\_\_ yes \_\_\_ no

**HEALTH SERVICES *continued*:**

Injections of any kind    \_\_\_ yes \_\_\_ no

Use of Inhalation-Assistive Devices    \_\_\_ yes \_\_\_ no

Colostomy / Ileostomy Care    \_\_\_ yes \_\_\_ no

Glucose Testing    \_\_\_ yes \_\_\_ no

Suctioning    \_\_\_ yes \_\_\_ no

Decubitus or Wound Care    \_\_\_ yes \_\_\_ no

Catheterization    \_\_\_ yes \_\_\_ no

Other (*specify*): \_\_\_\_\_

Additional Comments: \_\_\_\_\_

**V. DIETARY SCREENING**

Type of Diet: \_\_\_\_\_

Food Likes / Preferences: \_\_\_\_\_

Food Dislikes: \_\_\_\_\_

Special Mealtime Equipment: \_\_\_\_\_

Additional Dietary Information: \_\_\_\_\_

**SKILLS ASSESSMENT**

**VI. SELF HELP (*circle independence level*):**

Eating Skills:      Independent      Partial Assist      Hand-Over-Hand      Full Assist

Special Equipment: \_\_\_\_\_

Special Needs: \_\_\_\_\_

Dressing Skills:      Independent      Partial Assist      Hand-Over-Hand      Full Assist

Special Equipment: \_\_\_\_\_

Special Needs: \_\_\_\_\_

**SELF-HELP continued**

Toileting Skills:      Independent      Partial Assist      Hand-Over-Hand      Full Assist

Special Equipment: \_\_\_\_\_

Special Needs: \_\_\_\_\_

Grooming Skills:      Independent      Partial Assist      Hand-Over-Hand      Full Assist



Special Equipment: \_\_\_\_\_

Special Needs: \_\_\_\_\_

Communication Skills:	Non-Verbal	Verbal
Communication Methods (facial expressions, communication board, etc.): _____		
_____		

Special Equipment: \_\_\_\_\_

\_\_\_\_\_

**VII. INDEPENDENT LIVING SKILLS (Circle Best Answer)**

Household Tasks:	Independent	Partial Assist	Hand-Over-Hand	Full Assist
W/C Mobility:	Independent	Partial Assist	Hand-Over-Hand	Full Assist
Uses Public Transportation:	Independent	Partial Assist	Full Assist	
Uses Money to Make Purchases:	Independent	Partial Assist	Full Assist	

**Cognitive:**

Understands Simple Instructions:	Yes	No
Understands Complex Instructions:	Yes	No
Counts:	Yes	No
Reads:	Yes	No
Writes:	Yes	No
Knows Own Name:	Yes	No
Knows Personal Information:	Yes	No
Discriminates Colors:	Yes	No
Discriminates Shapes:	Yes	No
Discriminates Days of Week:	Yes	No
Understands Concept of "Same":	Yes	No
Understands Concept of "Different":	Yes	No

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

**VIII. MOTOR SKILLS**

Extends Arms:	Yes	No
Grasps with Hands:	Yes	No
Holds Seated Position:	Yes	No
Rolls from Side to Side:	Yes	No
Bears Weight in Lower Extremities:	Yes	No
Mobility ( <i>specify</i> ):	_____	

**XI. BEHAVIORAL NEEDS**

Behavioral Issues: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific Programs for Management of Behavior: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reinforcers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**X. RECREATION AND LEISURE SKILLS**

Likes (*people, places, things, activities, and etc.*): \_\_\_\_\_  
\_\_\_\_\_

Dislikes: \_\_\_\_\_  
\_\_\_\_\_

Responses to Socialization: \_\_\_\_\_  
\_\_\_\_\_

Additional Recreational Information: \_\_\_\_\_  
\_\_\_\_\_



STEP  
CLIENT ADMISSIONS  
**APPLICATION FOR ENROLLMENT**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**AGENCY USE ONLY:**

Interview Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Program Participation Determination:

- Accepted into Program                       Not Accepted into Program (*state reason*):

\_\_\_\_\_  
\_\_\_\_\_

SDRC Notification: \_\_\_\_\_

*(Service Coordinator Name)*

Start Date: \_\_\_\_\_