

CHARACTERISTICS OF INDIVIDUALS YOU ARE WILLING TO ACCEPT IN YOUR FACILITY:

YES	MAYBE	NO	TYPE OF DISABILITY:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mild intellectual disability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moderate intellectual disability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe/profound intellectual disability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism
			OTHER DIAGNOSIS:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual offender
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
			AMBULATORY STATUS:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walks with difficulty
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses a walker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not walk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses a wheelchair
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is able to transfer (from wheelchair to other accommodation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is dependent on others to transfer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cognitively non-ambulatory
			MEDICAL NEEDS:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sight impaired:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No sight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac condition
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needs medications regularly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needs regular therapy and/or medical appointments
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires special diet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has food allergies
			SPECIAL MEDICAL CONDITIONS FOR CHILDREN:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral feeding tube (gastrostomy, PEG, jejunostomy)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total parenteral feeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiorespiratory monitor (apnea monitor)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ventilator
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen support
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary catheterization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis (peritoneal or venous)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ministrations imposed by tracheostomy, colostomy, ileostomy, or other medical or surgical procedures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Special medication regimen: injection, intravenous medication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medically Fragile: potential for permanent injury or death

CHARACTERISTICS OF INDIVIDUALS YOU ARE WILLING TO ACCEPT IN YOUR FACILITY:

YES	MAYBE	NO	RESTRICTED HEALTH CONDITIONS FOR ADULTS:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of inhalation-assistive devices
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colostomy/Ileostomy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Need for fecal impaction removal, enemas or suppositories
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of indwelling urinary catheters
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staph or other serious, communicable infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin-dependent diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wounds (Stage 1 or 2 dermal ulcer or an unhealed, surgically closed incision or wound)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy (feeding, hydration and care)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomies

CONDITIONS OF LIFE (NOT PROHIBITED OR RESTRICTED) FOR ADULTS

YES	MAYBE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of hazard awareness or impulse control
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumers with incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumers with contractures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumers who rely on others to provide <u>all</u> activities of daily living (consumers who require total care)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumers who use oxygen

COMMUNICATION LIMITATIONS:

YES	MAYBE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has no intelligible speech
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech difficult to understand
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impaired:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses sign language only
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses communication board
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing with aid

SELF-HELP SKILLS:

YES	MAYBE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is not toilet trained
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinent during the day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinent during the night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with toileting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with dressing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with bathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with grooming (hygiene)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with eating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires range of motion training
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires mobility training (wheelchair/walker)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires training to access the community (transportation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires pedestrian safety training

CHARACTERISTICS OF INDIVIDUALS YOU ARE WILLING TO ACCEPT IN YOUR FACILITY:

SELF-HELP SKILLS (cont'd):

YES	MAYBE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with shopping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with budgeting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with social skills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with table manners
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with meal preparation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Requires assistance with household chores

BEHAVIORS:

YES	MAYBE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of physical violence to others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Threatens physical violence to others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is physically violent toward others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of injury to self
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Threatens injury to self
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is self-injurious
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Causes property damage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runs or wanders away
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Displays unacceptable sexual behavior
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has tantrums
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smears feces
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sets fires
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of hazard awareness or impulse control

OTHER (Please specify):

YES	MAYBE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Male only
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Female Only
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Either Male or Female
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Day program required
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	