Redwood Coast Regional Center

Respecting Choice in the Redwood Community

Intake Inquiry Packet

For Individuals 3 years of age or older

Thank you for your inquiry for services with Redwood Coast Regional Center (RCRC). RCRC is an agency that serves persons with developmental disabilities in a 4 county area. Persons served by our agency include those with an **Intellectual Disability, Autism**, **Cerebral Palsy, Epilepsy** or a condition closely related to intellectual disability or requiring treatment similar to that required by individuals with an intellectual disability. In addition, the condition needs to have originated prior to age 18, and can be expected to continue indefinitely; and it constitutes a substantial disability for that individual. For further information about Regional Center eligibility we recommend that you check out our website at www.redwoodcoastrc.org or the State Department of Developmental Services' website at www.dds.ca.gov.

As part of this initial process, the Intake Specialist will want to start collecting records and reports to help establish the suspicion of a developmental disability. Included with this packet, you will find a list of the types of records that are helpful to us. **Your assistance in helping us obtain these records is greatly appreciated and may help speed up the Intake & Eligibility process.** Please also complete, to the best of your ability, the enclosed RCRC Intake Information Form.

When you have obtained copies of the records/reports, completed the RCRC Intake Information Form, and are ready to send them in, you can forward them to:

☐ **UKIAH**	☐ **EUREKA**
Redwood Coast Regional Center 1116 Airport Park Blvd. Ukiah, CA 95482 Attn: Director of Intake, **LORI GUTIERREZ** **FAX:** (707) 462-3314 Attn: Director of Intake, **LORI GUTIERREZ**	Redwood Coast Regional Center 525 2nd Street, Suite 300 Eureka, CA 95501 Attn: Director of Intake, **LORI GUTIERREZ** **FAX:** (707) 444-3409 Attn: Director of Intake, **LORI GUTIERREZ**

Please note that sending the records and completed RCRC Intake Information Form assists RCRC in establishing the suspicion of a developmental disability. These documents will be forwarded on to an assigned Intake Specialist who will then be calling you as soon as possible to discuss the next steps of the intake process. We realize applicants' situations are specific to their needs, which requires certain records, and helping us in obtaining all of those records that do pertain is greatly appreciated.

If you have any questions on your next steps or need assistance with completing this process please call us at (707) 462-3832.

Sincerely,

The Intake & Eligibility Team

Redwood Coast Regional Center
Intake & Eligibility
Records and Reports Request List

Your assistance in obtaining these records is greatly appreciated and may help speed up the process.

✓		
	Psychological Evaluations	**All** evaluations completed by a licensed psychologist (PhD, PsyD).
	School Records	
	IEP (Individual Educational Program)	This includes goals and service plans. We NEED the latest and all Triennials (done every 3 years). We would like to have as many as you can obtain.
	School Psychological Evaluations	**All** Psycho-Educational reports done by the school psychologist (MS, MA, EdD).
	Speech Therapy Reports	Reports by school and/or private practice speech pathologists (SLP).
	Occupational Therapy Reports	Reports by school and/or private practice occupational therapists (OT).
	Physical Therapy Reports	Reports by school and/or private practice physical therapists (PT).
	Teacher notes	Notes, letters, reports from school personnel that describe the daily functioning of the applicant.
	Medical Records	
	Neurologist/Psychiatrist notes	Information from neurological/psychiatric medical doctors (MD/DO).
	Medical records	Records that are RELATED TO THE DEVELOPMENTAL DISABILITY and major medical issues (e.g. syndromes, genetics, etc.).
	Psychiatric Hospital Intake/Discharge	Records from any psychiatric hospital(s).
	Legal Records (if applicable)	
	Legal guardianship of a minor	Need final Letter of Guardianship document from court.
	Adopted minor	Need either changed birth certificate or final adoption document from court.
	Conservatorship (of an adult)	Need final Letter of Conservatorship document from court.

We realize that for various reasons an applicant may not have every kind of record(s). However, we do recommend that you make every effort to gather them and share a copy with the Regional Center. The Intake Unit will need to review as many of these that are available as part of the intake and eligibility process. These are also good to have for your own records if you do not yet have a copy for yourself.

Redwood Coast Regional Center

WHICH ONE OF OUR CRITERIA ARE YOU REFERRING FOR?

☐ Intellectual Disability ☐ Autism ☐ Cerebral Palsy ☐ Epilepsy

SOCIAL DATA BASE QUESTIONNAIRE

APPLICANT INFORMATION/IDENTIFYING INFORMATION:

(Relates to person for whom services are requested)

NAME: ______________________________ **Social Security #:** ___________________
(first) (middle) (last)

Is applicant known by another name? ____

Address: (Residence) ____

(Mailing) ____

Telephone: _____________ **DOB:** ________ **Age:** ____

Gender: ______________ **Preferred Pronouns:** ____________________

Birthplace:____________ **Email Address:** ____________________________________
(if minor, parent's email address)

ETHNICITY: __________________

APPLICANT PRIMARY LANGUAGE: ____

PREFERRED LANGUAGE FOR MEETINGS: ____________________________________

PREFERRED LANGUAGE FOR WRITTEN DOCUMENTATION: ________________________

Phone number to leave message: ____

Height: _____ **Weight:** ______ **Marital Status:** _______________________
(single / married / divorced / widowed)

Emergency Contact: (person other than household member)

____
(name) (relationship)

____
(address) (city) (zip) (telephone)

If applicant is non-English speaking (including ASL) or deaf, person to translate:

____
(name) (telephone)

Applicant's current living arrangements and family dynamics, who lives in home, how long in current home, list extended family members in home, pets, etc.:

____

____

____

Who referred you to the Redwood Coast Regional Center? ______________________________

Are any other family members clients of Redwood Coast Regional Center? Y / N

Name of client: ______________________ **Case Manager:** __________________________

FAMILY INFORMATION:

Marital status of biological parents:

☐ **married** ☐ **divorced** ☐ **separated**

☐ **widowed** ☐ **single** ☐ **never married**

Is either parent deceased?

Mother: Y / N Date: __________ **Father: Y / N Date:** __________

Custody of applicant: (if minor)

☐ **Mother** ☐ **Father** ☐ **Legal Guardian**

Terms of custody: ____

Is the person seeking services conserved? Y/N. If yes, name of guardian/conservator? ____

Relationship to person seeking services? ____

State where conservatorship was filed: ______________ **Date filed:** ______________________

Did / Does applicant live with natural parents or in foster care?___________________________

Has the court assigned a legal guardian or conservator? Y / N

Date when the records were obtained: ____________

Location where the records were obtained: ____

Foster parent / legal guardian / conservator name(s), including telephone numbers and address: ____

____

(Dirección) **(Teléfono)**

Who holds Educational Signing Rights? ____

Who holds Parental Signing Rights including Medical? __________________________________

Has applicant had any arrests or convictions? Y / N

If yes, for what? ____

Is applicant on probation? Y / N

Name of Probation Officer: ________________________

APPLICANT'S BIOLOGICAL MOTHER: **(full name including maiden, specify if you are the adoptive parent):**

Name: ____

Address: ____

Telephone: ___________________ DOB: ______________________

SOCIAL SECURITY# ___________________ Occupation: _____________

Birthplace: ___________________ Military/Branch? _________________

Educational Level: _______________

Employer name/address: ____

APPLICANT'S BIOLOGICAL FATHER: **(full name, specify if you are the adoptive parent):**

Name: ____

Address: ____

Telephone: ___________________ DOB: ______________________

SOCIAL SECURITY# ___________________ Occupation: _____________

Birthplace: ___________________ Military/Branch? _________________

Educational Level: _______________

Employer name/address: ____

STEP-PARENT: **(full name):**

Name: ____

Address: ____

Telephone: ___________________ DOB: ______________________

SOCIAL SECURITY# ___________________ Occupation: _____________

Birthplace: ___________________ Military/Branch? _________________

Educational Level: _______________

Employer name/address: ____

APPLICANT'S SIBLINGS: **(names and ages): ____**

____

APPLICANT'S SPOUSE: (name and age): ____

APPLICANT'S CHILDREN: (names and ages): ____

____

CARE PROVIDER: (If other than parents): ____

Address: ____

Telephone #:__________________ Relationship: ______________________________

FAMILY HEALTH HISTORY:

Is applicant adopted? _____________________

Ethnicity of biological family: _______________________

Is there a biological family history of any of the following:

		(Relation, include all family members)
Intellectual Disability (Mental Retardation)	Y / N	______________________
Autism Spectrum Disorder	Y / N	______________________
ADD/ADHD	Y / N	______________________
Seizures (epilepsy)	Y / N	______________________
Cerebral Palsy	Y / N	______________________
Muscle disease	Y / N	______________________
School problems	Y / N	______________________
Birth Defects	Y / N	______________________
Diabetes	Y / N	______________________
Heart Trouble	Y / N	______________________
Speech problem	Y / N	______________________
Hearing problem	Y / N	______________________
Substance Abuse	Y / N	______________________
Mental/Emotional Illness	Y / N	______________________

(If yes, please describe):

____

____

Any other health problems in the birth family? Y / N

____

____

MEDICAL HISTORY:

Pregnancy/Delivery History (*mother of applicant*):

Age of parents at delivery: Mother: _____ Father: _____

Total number of pregnancies: _____ Live births: _____ Miscarriages: _____

Have you had any children who have died? _____ If yes, age at death: _____

Cause of death: ____________________

Birth order of applicant (2nd, 5th, etc.): _____

Did the mother have regular prenatal care? ______ If yes, when did medical care begin? _____

Total weight gained? _______

Did mother lose weight during the pregnancy? Y / N If yes, how much? _____

HEALTH DURING PREGNANCY:

Illnesses: ____

Did birth mother of applicant have any of the following during pregnancy?

Gestational Diabetes?	Y / N	________________________________
Toxemia	Y / N	________________________________
Infections	Y / N	________________________________
High blood pressure	Y / N	________________________________
Bleeding	Y / N	________________________________
Rubella	Y / N	________________________________
Smoking	Y / N	________________________________
Alcohol/Drug Intake	Y / N	________________________________
Other	Y / N	________________________________

Medication taken during pregnancy:	Reason taken:
___________________________	__________________________
___________________________	__________________________

How long (in weeks or months) was pregnancy? ____________

Where was baby born? Home Y / N Hospital Y / N

If born in hospital, name of hospital: ____________________ City: ________

Length of labor (hours): ______________

Type of delivery: ☐ vaginal ☐ caesarian section (scheduled / emergency)

Anesthetic if C-Section: ☐ spinal ☐ epidural ☐ general

Presentation: ☐ head first ☐ feet first ☐ other

Birth Weight: _____lb. _____oz. **Length:** _____ inches

APGAR scores: 1 minute: _____ **5 minutes:** _____

Post delivery complications:

☐ Trouble breathing	☐ Jaundice
☐ Blue color	☐ Poor suck: describe: _____________________
☐ Needed oxygen	☐ Birth defect
☐ Needed IV antibiotics	☐ Muscle tone very limp
☐ Needed transfusion	☐ Muscle tone very stiff

Total number of days baby remained in hospital: _____

Baby was fed by: ☐ Breast ☐ Bottle ☐ Both

Was the baby mechanically assisted? ☐ NG tube ☐ OG tube ☐ GT tube

Following the birth and during the first 12 months, did the child have any difficulties/ health problems such as jaundice, cyanosis (turning blue), convulsions or seizures, infections, sleeping or feeding difficulties? Any other problems in the first year that required hospitalizations? If yes, why?

____

____

____

Did the mother have any health problems after delivery? Y / N

If yes, please explain:

____

____

DEVELOPMENTAL HISTORY:

Indicate age (in months) when applicant ***first*** did each of the following:

Motor Domain:	age in months	Self-Help Domain:	age in months
Sat without support	_____	Finger feeding	______
Drank from cup	_____	Used spoon fairly well	______
Walked with support (cruising)	_____	Toilet training completed	______
Walked without support	_____	Dressed self	______
Rode tricycle	_____		
Crawled	_____		

Social Domain:		Communication Domain:	
Played alone	______	Babbled (said "mama", etc.)	_____
Played alongside other children	______	Said other single words	_____
Played with other children	______	Spoke phrases	_____
Age child had favorite activity	______	Spoke in sentences	_____
Age child had favorite toy	______		

Cognitive Domain:

Knew body parts	______	Counted to 10	_____
Knew some colors	______	Knew "ABC Song"	_____

How old was the applicant when you first became concerned about his/her development? _____ Why? ____

____

Has s/he lost any developmental skills s/he once had? At what age? Please describe:

____

____

____

Applicant Health History:

Please check any of the following the applicant has had and explain. Give age when it occurred. Please include the year because it facilitates obtaining records.

	Age / Year:	Name and Address of Hospitals, Description of Care:
☐ **Hospitalizations**	_____	__________________________________
☐ **Surgeries**	_____	__________________________________
☐ **Serious injuries / traumatic brain injury / accidents**	_____	__________________________________
☐ **Serious illness or frequent illness**	_____	__________________________________
☐ **Allergies**	_____	__________________________________
☐ **Pregnancies**	_____	__________________________________
☐ **Tests / evaluations**		
Psychiatric	_____	__________________________________
Hearing	_____	__________________________________
Vision	_____	__________________________________
MRI / CT scan	_____	__________________________________
X-ray	_____	__________________________________
Psychological	_____	__________________________________

Special Equipment: **Please list any special equipment used by or for the applicant (feeding, mobility, glasses, braces, etc.)**

____

____

Current Medications:

Name	How Much, How Often	Reason

Seizures: **(Current frequency of seizures)**

(If the applicant does not have seizures, skip this section.)

☐ **more than one per day**	☐ **7 to 11 per year**
☐ **one per day**	☐ **1 to 6 per year**
☐ **one per week**	☐ **none in the past year (controlled by meds)**
☐ **one per month**	☐ **none in ____ years**

Seizure type or description of seizure: ____

____

Pre-seizure aura? Y / N   Describe____

Condition after seizure: ____

Recovery time after seizure: ____

Status epilepticus (prolonged seizures) seizures? Y / N

Is medication prescribed regularly administered and under the direction of a primary care provider and / or neurologist? List Neurologist and date last seen.

____

____

Current Primary Physician: ____

Address: ____

Phone #: ____________________   **Date last seen:** __________________

Reason seen: ____

Dentist: ____

Date last seen: ____

Other current physicians and / or prior physicians seen and their specialties: **(Please include name and addresses and dates seen)**

____

____

____

BEHAVIOR REVIEW:

Has / does the applicant have any of the following behavior challenges? If so please describe. Please describe any of the following concerns:

- ☐ **Sleep problems:** ____________________
- ☐ **Daytime wetting:** ____________________
- ☐ **Fearfulness:** ____________________
- ☐ **Temper Tantrums:** ____________________
- ☐ **Separation difficulties:** ____________________
- ☐ **Stealing:** ____________________
- ☐ **Excessive lying:** ____________________
- ☐ **Aggressiveness:** ____________________
- ☐ **Eating Problems:** ____________________
- ☐ **Bowel soiling/smearing:** ____________________
- ☐ **Self-injury behavior:** ____________________
- ☐ **Cries often / easily:** ____________________
- ☐ **Restless:** ____________________
- ☐ **Difficult to discipline:** ____________________
- ☐ **Self- stimulating behavior:** ____________________
- ☐ **Rocking/twirling:** ____________________
- ☐ **Hyperactive behavior:** ____________________
- ☐ **Difficulty with eye contact:** ____________________
- ☐ **Echolalia or repetitive speech:** ____________________
- ☐ **Sensitivity to touch, smells, textures:** ____________________
- ☐ **Fascination with spinning objects:** ____________________
- ☐ **Difficulty with change in routine:** ____________________
- ☐ **Prefers to be alone:** ____________________
- ☐ **Difficulty playing with other children:** ____________________

Any other behavior concerns: (Please explain):

____

____

____

EDUCATIONAL HISTORY:

Name of infant program or preschool: ____

Teacher: ____________________________ Type of class: ________________________

School: Age when you started to go to school: ______

List Current or last school attended:

Name / Address of School	Type of class	Last Year Attended	Teacher	Phone
____________________	__________	_____	_________	__________
____________________	__________	_____	_________	__________
____________________	__________	_____	_________	__________

Individual Educational Plan (IEP): Y / N If yes, indicate disability for IEP:

____

Behavioral Plan Y / N If yes, describe the need for the behavioral plan:

____

WORK EXPERIENCE / VOCATIONAL HISTORY:

(If no vocational activities yet, skip this section.)

What types of jobs has applicant had? ____

____

____

Is applicant now or has s/he ever been involved with Vocational Rehabilitation? Y/N

Intake Specialist will inform the applicant of their Legal Rights.

(Fair hearing process, appeal procedures)

FINANCIAL SITUATION:

Benefits/Health Insurance: (Please check benefits applicant receives and amounts)

SSI: $_____   SSA: $_____   AFDC: $_____   Other: ____________: $_____

Payee: ____________________

☐ **Applicant receives no public benefits**

Applicant has the following Insurance:

☐ **Medi-Cal #: ___________________** ☐ **Medicare #: ___________________**

Issue Date: _________________

☐ **CHAMPUS #: __________________** ☐ **Other: ________________________**

☐ **PRIVATE INSURANCE: (Name of Insurance Co.): __________________________**

Policy Number: _______________________

Does applicant receive In-home Support Services (IHSS)? Y / N

If so, number of hours per month: ______

OTHER AGENCIES INVOLVED:

Please list any other agencies which have provided services to the applicant (e.g.- CCS, Social Security, Head Start, Mental Health, etc):

____

____

CURRENT AREAS FOR INTERVENTION:

What types of services do you feel the applicant needs? ______________________

____

____

____

This report completed by: ____________________________________

Date of report: ____

....

FOR RCRC USE ONLY

....

Intake Specialist: ____

Date of Face to Face: ____