



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:

<input type="checkbox"/> UKIAH Redwood Coast Regional Center 1116 Airport Park Blvd. Ukiah, CA 95482 Attn: Director of Intake FAX: (707) 462-3314 Attn: Director of Intake	<input type="checkbox"/> EUREKA Redwood Coast Regional Center 525 2 nd Street, Suite 300 Eureka, CA 95501 Attn: Director of Intake FAX: (707) 444-3409 Attn: Director of Intake
--	--

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	<u>All</u> 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	<u>All</u> 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:

<u>Motor Domain:</u>	age in months	<u>Self-Help Domain:</u>	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	_____		

<u>Social Domain:</u>		<u>Communication Domain:</u>	
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:
<input type="checkbox"/> Hospitalizations	_____	_____
<input type="checkbox"/> Surgeries	_____	_____
<input type="checkbox"/> Serious injuries / traumatic brain injury / accidents	_____	_____
<input type="checkbox"/> Serious illness or frequent illness	_____	_____
<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Pregnancies	_____	_____
<input type="checkbox"/> 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:

<u>Name</u>	<u>How Much, How Often</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Seizures: (Current frequency of seizures)

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

- | | |
|--|---|
| <input type="checkbox"/> more than one per day | <input type="checkbox"/> 7 to 11 per year |
| <input type="checkbox"/> one per day | <input type="checkbox"/> 1 to 6 per year |
| <input type="checkbox"/> one per week | <input type="checkbox"/> none in the past year (controlled by meds) |
| <input type="checkbox"/> one per month | <input type="checkbox"/> 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:

<u>Name / Address of School</u>	<u>Type of class</u>	<u>Last Year Attended</u>	<u>Teacher</u>	<u>Phone</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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: _____