Route to:
All-Ways Care Plus (serves adults & children)
Blue Water Developmental Housing (serves adults & children)
CE Community Supports (serves adults only)
Impact (serves adults only)
Innovative (serves adults only)
Spectrum Community Services (serves adults & children)

Date: _____

St. Clair County Community Mental Health Authority
Consumer Profile

Case Number: _____ Age: _____ ☐ Male ☐ Female

☐ H/SW ☐ B3 ☐ Children's Waiver

Address: _____ City: _____

Contact Person: _____ Program Site: _____

Phone Number: _____ Please respond no later than: _____

Support Services Requested:

Community Living Supports ☐ Skill Building ☐
Respite ☐ Other: _____ ☐

NEEDS:

Personal Care:

	Provide/Assist	Guide/Direct	N/A
Eating/Feeding	☐	☐	☐
Toileting Briefing ☐	☐	☐	☐
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Grooming	☐	☐	☐
Transferring	☐	☐	☐
1 Person ☐			
2 Person ☐			
Mechanical Lift ☐			
Ambulation/Mobility	☐	☐	☐
Taking Medication	☐	☐	☐

Adaptive Equipment**:** (i.e. wheelchair, walker, communication aid)_____

Consumer requires handicapped accessible transportation:

☐ Yes ☐ No

This consumer is:

☐ Verbal ☐ Non-Verbal

☐ Uses Sign Language ☐ Challenging Behavior ☐ Yes ☐ No

Is Behavior Plan in Place? ☐ Yes ☐ No

(Explain): _____

I would prefer my support worker be: ☐ Male ☐ Female ☐ Does not matter

Goal(s) to be implemented by the support worker, per the IPOS: (Use additional pages if necessary)

Goal: _____

_____

_____

Objective: _____

_____

_____

_____

Intervention: _____

_____

_____

_____

Number of hours/week authorized _____

Days of the week support required/Start & Stop Time:

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Staff Special Training Needs: _____