ECHOING HILLS

Adult Services Programs Prospective Individual Information Sheet

ECHOINGU of Southwest Ohio		ECHOING CONNECTIONS of Southwest Ohio
Name (Last, First)		Today's Date: / /
Estimated Enrollment Year:	Age:	DOB: / /
Parent/Guardian Name(s):		
Address:		
County:		
Parent email(s):	Individual email:	
Parent Phone#:	Individual Phone#:	
High School Attended:		
Do you have a Medicaid Waiver? (ex: Level 1, IO or SELF)		
Do you have an SSA/County Board Representative? If so, who?		
SSA/County Board Representative email:		
Do you need transportation provided?		

Any additional information we should know:
BACK -->

echoingU Southwest Ohio
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	Yes	No	Comments
Independent in self-care (eating, drinking, dressing, hygiene and toileting)			
Independent in mobility			
Able to self-carry/administer medications without assistance if needed during program hours			
Requires nursing needs during program hours			
Interested/able to participate in classroom setting			
Able to participate without disruption to others			
Able to de-escalate emotional reactions independently (no counselor on duty)			
Able to communicate thoughts, desires, feelings, wants and needs			

Any additional information we should know: