JOURNEY21

Participant Information & Assessment

Indicate Journey21 Program Interest: (check all that apply)

- □ 18-21 Transition Academy
- □ Life Academy
- □ Summer Academy
- □ Life Enrichment Program
- □ Programs & Outings

Participant Information:

Name: _____
Nickname: _____
Date of Birth: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Email: _____
Gender: _____
Ethnicity: _____
Pronouns: _____

Does the participant have a legal guardian? ☐ Yes ☐ No

If yes, please list who the guardian is? _____

Guardian Contact Information:

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Relationship: _____

Guardian Contact Information:

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Relationship: _____

EMERGENCY CONTACT:

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Relationship _____

Was the participant adopted? ☐ Yes ☐ No **If yes, at what age and please indicate anything notable:**

Waiver/Funder Contacts:

What is your current waiver funding? ☐ IRIS ☐ CLTS ☐ MyChoice ☐ Community Care ☐ N/A

If you have waiver funding, please provide contact name for IRIS Consultant, Family Care Case Manager or CLTS Case Worker:

Name: _____
Company: _____
Work Phone: _____
Email: _____

Does the participant experience difficulties with: (if yes, please describe.)

Ambulation: ☐ Yes ☐ No	
Vision: ☐ Yes ☐ No	
Hearing: ☐ Yes ☐ No	
Communication: ☐ Yes ☐ No	

INTERESTS/PREFERENCES/NON-NEGOTIABLES:

My favorite:

Foods/Restaurants:	
Sports:	

Movies/Books:	
Music:	

I have non-negotiables (objects/activities/etc.)

I enjoy participating in the following activities (please check all that apply):

☐ Music	☐ Theatre	☐ Movies	☐ Cooking	☐ Art
☐ Legos	☒ Exercise	☐ Sports	☐ Baking	☐ Hiking
☐ Bowling	☐ Dancing	☐ Pickleball	☐ Swimming	☐ Board Games
☐ Special Olympics (please specify):				
☐ Other (please specify):				

MEDICAL HISTORY: (feel free to attached information)

Diagnoses:	
Medical Conditions:	
Medications:	
Do you take any medications during the day? ☐ Yes ☐ No	
Do you need assistance with these medications while at Journey21? ☐ Yes ☐ No	

Does the participant have allergies? ☐ Yes ☐ No **If yes, please list what kind?**

Medication:	
Food:	
Seasonal:	
Other:	

Does the participant have a history of seizures? ☐ Yes ☐ No

Date of last seizure:	
Frequency:	
Type – what to expect:	
Response Protocol:	

Does the participant sustain a brain injury? ☐ Yes ☐ No If yes, complete below:

Date injury occurred:	
Type/location of brain injury if known	
Severity of injury:	
Personality changes due to injury?	☐ Yes ☐ No ☐ Unknown or unable to determine.

Does the participant have a special diet? ☐ Yes ☐ No **If yes, please describe:**

TRAUMA HISTORY:

Does the participant have a known history of being abused? ☐ Yes ☐ No **If yes, at what age and please indicate type of abuse:**

Does the participant have a known history of being neglected? ☐ Yes ☐ No **If yes, at what age and please describe:**

Has the participant experienced other traumatic events? ☐ Yes ☐ No **If yes, at what age and please describe:**

Behavior/Self-Advocacy

I am sensitive to noisy environments or bright lights	☐ Yes	☐ No
I use an appropriate tone of voice	☐ Yes	☐ No
I am comfortable starting a conversation	☐ Yes	☐ No
I give personal space to the people around me	☐ Yes	☐ No
I display appropriate behaviors in public	☐ Yes	☐ No
If I don't understand directions, I ask for help	☐ Yes	☐ No
I need 2 or less prompts to stay on task	☐ Yes	☐ No
I become frustrated or anxious easily	☐ Yes	☐ No
I interrupt and can dominate a conversation	☐ Yes	☐ No
I can follow simple directions	☐ Yes	☐ No
I have a difficult time putting down my phone or tablet	☐ Yes	☐ No
I ask for help or speak up when I don't understand something	☐ Yes	☐ No

PROGRAM/WORK HISTORY:

Has the participant attended an Adult Day or Vocational Services Program? ☐ Yes ☐ No
If yes, please indicate:

Has the participant ever been dismissed or suspended from any program? ☐ Yes ☐ No
If yes, please state the circumstances and date(s)?

Is the participant currently employed? ☐ Yes ☐ No
Has the participant had employment in the past? ☐ Yes ☐ No

If yes, to either above question, please describe:

SHORT/LONG-TERM GOALS:

_____ _____

Name of Person Completing the Information Form Date