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| **NAME:** | Click here to enter text. | | | | | | | | | **DATE:** | | Click here to enter a date. | | | **DDD ID#:** | | | Click here to enter text. | |
| **Residential Provider** | | | **Residential Address** | | | | | | **Contact Person** | | | | **Phone** | | | | | **Email** | |
| Click here to enter text. | | | Click here to enter text. | | | | | | Click here to enter text. | | | | Click here to enter text. | | | | | Click here to enter text. | |
| **Day Services Provider** | | | **Day Services Address** | | | | | | **Contact Person** | | | | **Phone** | | | | | **Email** | |
| Click here to enter text. | | | Click here to enter text. | | | | | | Click here to enter text. | | | | Click here to enter text. | | | | | Click here to enter text. | |
| **Form completed by:** | | | **Title** | | | | | | **Phone** | | | | **Email** | | | | | **Supervisor** | |
| Click here to enter text. | | | Click here to enter text. | | | | | | Click here to enter text. | | | | Click here to enter text. | | | | | Click here to enter text. | |
| **Behavior Specialist** | | | | | | | | | **Phone** | | | | | | | | | **Email** | |
| Click here to enter text. | | | | | | | | | Click here to enter text. | | | | | | | | | Click here to enter text. | |
| **Is Crisis Assessment Response & Enhanced Services (CARES) involved?** Yes No | | | | | | | | | | | | | | | | | | | |
| **CARES Clinician** | | | | | | | | | **Phone** | | | | | | | | | **Email** | |
| Click here to enter text. | | | | | | | | | Click here to enter text. | | | | | | | | | Click here to enter text. | |
| **Ambulation Status:**  Ambulatory  Non-Ambulatory  Ambulates with assistance | | | | | | | | | | | | | | | | | | | |
| **NJCAT Score:** | | | | | | | | | | | **Tier/Acuity:** | | | | | | | | |
| **Communication Style:**  Vocal Speech  Gestures  None  American Sign Language (ASL)  Picture Exchange Communication System (PECS)  Augmentative Alternative Communication (AAC) | | | | | | | | | | | | | | | | | | | |
| **Please complete for the behaviors of highest concern.** | | | | | | | | | | | | | | | | | | | |
| **Behavior Label:** | | | | | Click here to enter text. | | | | | | | | | | | | | | |
| **Frequency:** | | Click here to enter text. | | | Description: | | | Click here to enter text. | | | | | | | | | Severity: | | Mild  Moderate  Severe |
| **Behavior Label:** | | | | | Click here to enter text. | | | | | | | | | | | | | | |
| **Frequency:** | | Click here to enter text. | | | Description: | | | Click here to enter text. | | | | | | | | | Severity: | | Mild  Moderate  Severe |
| **Behavior Label:** | | | | | Click here to enter text. | | | | | | | | | | | | | | |
| **Frequency:** | | Click here to enter text. | | | Description: | | | Click here to enter text. | | | | | | | | | Severity: | | Mild  Moderate  Severe |
| **Psychiatric Diagnosis:** | | | | Click here to enter text. | | | | | | | | | | | | | | | |
| Are psychotropic medications prescribed? (If yes, please attach the list) | | | | | | | | | | | | | | | | Yes | | | No |
| **Guardian Name:** | | | | | | **Phone:** | | | | | | | | **Guardian Type:** | | | | | |
| **Please submit the following documents with this form (if available):** | | | | | | | | | | | | | | | | | | | |
| Current Service Plan | | | | | | | Functional Behavior Assessment | | | | | | | Behavior Support Plan | | | | | |
| Current Psychological Evaluation | | | | | | | Current Psychiatric Evaluation | | | | | | | Risk Assessment or Social History | | | | | |