IT'S NOT SOMETHING
IT'S EVERYTHING

INDIVIDUAL INTAKE & ENROLLMENT PACKET

Community Access Individual (CAI)

CURRENT SERVICE: Community Access Individual (CAI). Community Access Group (CAG) and Community Living Support (CLS) sections are reserved for future agency use and are not currently offered.

Applicant / Individual	Date Packet Started
Person Completing Packet	Relationship to Individual

Changing the Narrative of IDD Support

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WELCOME & PACKET INSTRUCTIONS

Our Mission

It's Not Something, It's Everything, LLC provides quality, person-centered support that helps individuals with intellectual and developmental disabilities build independence, connect with their communities, and pursue meaningful, self-directed lives.

How to Use This Packet

☐ Complete every section that applies
☐ Write N/A when a question does not apply
☐ Attach current medical and support records
☐ Sign each required consent or acknowledgment
☐ Keep a copy for your records
☐ Notify the agency when information changes
Submitting this packet does not guarantee admission. Enrollment is based on service authorization, assessment, compatibility, staffing capacity, health and safety needs, and the agency's ability to provide the requested supports.

Service Status

Service	Status	Use of Packet
Community Access Individual (CAI)	CURRENT	Complete all applicable sections
Community Access Group (CAG)	FUTURE USE ONLY	Do not select until agency confirms availability
Community Living Support (CLS)	FUTURE USE ONLY	Do not select until agency confirms availability

APPLICATION FOR SERVICES

☐ CAI - Community Access Individual (currently available)

☐ Private-pay CAI inquiry

☐ CAG - Future use only

☐ CLS - Future use only

Application date

Legal name of individual

Preferred name

Date of birth

Pronouns

Social Security number (last four digits only)

Home address

City / State / ZIP

County

Primary phone

Email

Preferred communication method

Person assisting with this application

Relationship to individual

Referral source / organization

Referral contact name and phone

LEGAL REPRESENTATIVE & EMERGENCY CONTACTS

☐ Individual makes own decisions	☐ Parent/family supporter
☐ Legal guardian	☐ Healthcare agent
☐ Representative payee	☐ Other authorized representative
Attach current guardianship, power of attorney, or other legal-authority documents when applicable.	

Legal representative / guardian name

Relationship

Address

Phone

Email

Type and scope of legal authority

Emergency Contact 1

Name

Relationship

Primary phone

Alternate phone

Email

Address

Emergency Contact 2

Name

Relationship

Primary phone

Alternate phone

Email

Address

FUNDING, WAIVER & SERVICE COORDINATION

☐ NOW Waiver ☐ COMP Waiver

☐ Private pay ☐ Planning list

☐ Other funding ☐ Not yet determined

Medicaid ID

Waiver effective date

Fiscal intermediary (if participant-directed)

Support Coordination agency

Support Coordinator name

Support Coordinator phone

Support Coordinator email

Current service authorization / units

Current ISP effective dates

Other current providers and services

Provide the current ISP and service authorization before services begin. The agency will deliver only authorized, accepted services within its approved scope.

HEALTH & MEDICAL PROFILE

Primary diagnosis / disability

Secondary diagnoses

Primary care provider

Provider phone

Preferred hospital

Dentist and phone

Pharmacy and phone

Height

Weight

Blood type (if known)

Date of most recent physical

Date/result of TB screening, if required

- ☐ Seizure disorder
- ☐ Diabetes
- ☐ Asthma / respiratory condition
- ☐ Cardiac condition
- ☐ Mobility limitation
- ☐ Vision impairment
- ☐ Hearing impairment
- ☐ Communication support need
- ☐ Swallowing / aspiration risk
- ☐ Fall risk
- ☐ Allergies
- ☐ Other significant condition

Describe checked conditions, warning signs, and required supports

MEDICATION & ALLERGY RECORD					
Medication	**Dose**	**Route**	**Time/ Frequency**	**Reason**	**Prescriber**

☐ No current medications

☐ Needs reminders only

☐ Emergency/rescue medication present

☐ Medication is self-administered

☐ Needs assistance consistent with authorization

☐ Medication list attached

Allergies and Reactions

Allergen	Reaction	Severity	Response / Treatment

EMERGENCY & SAFETY INFORMATION

- ☐ Elopement / wandering risk
- ☐ Traffic safety support
- ☐ Choking / aspiration risk
- ☐ Seizure rescue plan
- ☐ Behavior crisis plan
- ☐ Aggression risk
- ☐ Limited danger awareness
- ☐ Water safety risk
- ☐ Falls / balance risk
- ☐ Diabetes emergency plan
- ☐ Suicide/self-harm concern
- ☐ None known

Early warning signs staff should recognize

Actions that help prevent escalation or injury

Actions staff should avoid

Emergency protocol / when to call 911

Who must be contacted after an emergency

Known triggers or high-risk settings

Safety equipment or assistive devices

If there is an immediate danger, medical emergency, or credible threat of harm, staff will call 911 and follow the individual's approved emergency plans and agency procedures.

COMMUNICATION & DECISION-MAKING PROFILE

- ☐ Speaks verbally
- ☐ Uses gestures
- ☐ Uses sign language
- ☐ Uses picture supports
- ☐ Uses AAC device
- ☐ Uses communication board
- ☐ Reads independently
- ☐ Needs simplified language
- ☐ Needs extra processing time
- ☐ Interpreter needed

Primary communication method

How the individual says yes

How the individual says no

How pain or distress is communicated

Best way to explain choices

Topics, words, or approaches to avoid

Who helps the individual make decisions

Important cultural or language considerations

PERSON-CENTERED PROFILE

What people like and admire about me

What is most important to me

What is important for my health and safety

My strengths, gifts, and interests

My favorite activities, places, foods, music, and people

Things I do not like

What a good day looks like

What a difficult day looks like

How staff can best support me

Goals I want to work on in the community

COMMUNITY ACCESS INDIVIDUAL (CAI) PROFILE

CAI is the agency's current service. Supports must follow the approved ISP, authorization, individual preferences, assessed needs, and applicable safety plans.

- ☐ Community participation
- ☐ Travel / transportation training
- ☐ Volunteering
- ☐ Shopping and money use
- ☐ Communication practice
- ☐ Social skill development
- ☐ Safety skill development
- ☐ Recreation and wellness
- ☐ Self-advocacy
- ☐ Building natural supports

Preferred community locations and activities

Transportation plan

Pickup location

Drop-off location

Usual service days and times

Staffing ratio authorized

Community goals from current ISP

Barriers to participation

Required accommodations

People or places to avoid / restrictions

How progress should be reported

DAILY SUPPORT & PERSONAL CARE NEEDS

- ☐ No personal care support anticipated
- ☐ Toileting assistance
- ☐ Eating support
- ☐ Mobility assistance
- ☐ Positioning support
- ☐ Dressing assistance
- ☐ Toileting reminders
- ☐ Menstrual support
- ☐ Meal preparation support
- ☐ Transfer assistance
- ☐ Hygiene reminders
- ☐ Other

Detailed instructions for personal care support

Diet order / texture / fluid consistency

Food preferences and restrictions

Mobility and transfer instructions

Adaptive equipment

Privacy, dignity, gender, or cultural preferences

BEHAVIORAL & EMOTIONAL SUPPORT

- ☐ No known behavioral support needs
- ☐ Behavior Support Plan attached
- ☐ Crisis Safety Plan attached
- ☐ Psychiatric provider involved
- ☐ History of trauma
- ☐ Anxiety
- ☐ Depression
- ☐ Property destruction
- ☐ Physical aggression
- ☐ Verbal aggression
- ☐ Self-injury
- ☐ Elopement
- ☐ Sexual safety concern
- ☐ Substance use concern
- ☐ Other

Behavior or concern and what it may communicate

Common triggers / setting events

Prevention strategies

Effective calming and coping supports

Reinforcers and motivators

Least-restrictive response strategies

Current clinician / behavior specialist

Date of most recent behavioral or psychological evaluation

This intake packet is not a clinical suicide assessment. Any current suicidal thoughts, threats, or immediate safety concerns require prompt evaluation by qualified emergency or behavioral health professionals.

SKILLS INVENTORY - RATING GUIDE		
Code	**Level**	**Description**
I	Independent	Completes safely without assistance
VP	Verbal Prompt	Needs spoken reminders or cues
GP	Gestural Prompt	Needs pointing or other nonverbal cues
M	Modeling	Needs someone to demonstrate the task
PA	Physical Assistance	Needs partial hands-on help
TA	Total Assistance	Needs full hands-on support
N/A	Not Assessed / Not Applicable	Not relevant or insufficient information

Personal Care

Skill / Activity	I	VP	GP	M	PA	TA	N/A
Walking / mobility	☐	☐	☐	☐	☐	☐	☐
Eating and drinking	☐	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐	☐
Handwashing	☐	☐	☐	☐	☐	☐	☐
Bathing / showering	☐	☐	☐	☐	☐	☐	☐
Oral care	☐	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐
Medication routine	☐	☐	☐	☐	☐	☐	☐
Recognizing pain / illness	☐	☐	☐	☐	☐	☐	☐

SKILLS INVENTORY - HOME & DAILY LIVING

Home and Daily Living

Skill / Activity	I	VP	GP	M	PA	TA	N/A
Laundry sorting	☐	☐	☐	☐	☐	☐	☐
Washing / drying clothes	☐	☐	☐	☐	☐	☐	☐
Folding and storing clothing	☐	☐	☐	☐	☐	☐	☐
Making bed	☐	☐	☐	☐	☐	☐	☐
Cleaning personal space	☐	☐	☐	☐	☐	☐	☐
Using microwave	☐	☐	☐	☐	☐	☐	☐
Using stove safely	☐	☐	☐	☐	☐	☐	☐
Preparing simple food	☐	☐	☐	☐	☐	☐	☐
Washing dishes	☐	☐	☐	☐	☐	☐	☐
Taking out trash	☐	☐	☐	☐	☐	☐	☐
Using household appliances	☐	☐	☐	☐	☐	☐	☐
Following a daily schedule	☐	☐	☐	☐	☐	☐	☐

Money and Personal Business

Skill / Activity	I	VP	GP	M	PA	TA	N/A
Identifying money	☐	☐	☐	☐	☐	☐	☐
Making a	☐	☐	☐	☐	☐	☐	☐

Skill / Activity	I	VP	GP	M	PA	TA	N/A
purchase							
Counting change	☐	☐	☐	☐	☐	☐	☐
Using debit card safely	☐	☐	☐	☐	☐	☐	☐
Budgeting	☐	☐	☐	☐	☐	☐	☐
Paying bills	☐	☐	☐	☐	☐	☐	☐
Protecting personal information	☐	☐	☐	☐	☐	☐	☐
Recognizing scams / exploitation	☐	☐	☐	☐	☐	☐	☐

SKILLS INVENTORY - COMMUNITY & SOCIAL

Community Safety and Access

Skill / Activity	I	VP	GP	M	PA	TA	N/A
Uses seat belt	☐	☐	☐	☐	☐	☐	☐
Follows traffic signals	☐	☐	☐	☐	☐	☐	☐
Uses crosswalks	☐	☐	☐	☐	☐	☐	☐
Stays with staff/group	☐	☐	☐	☐	☐	☐	☐
Recognizes unsafe situations	☐	☐	☐	☐	☐	☐	☐
Requests help	☐	☐	☐	☐	☐	☐	☐
Uses public transportation	☐	☐	☐	☐	☐	☐	☐
Identifies destination	☐	☐	☐	☐	☐	☐	☐
Carries emergency identification	☐	☐	☐	☐	☐	☐	☐
Follows emergency directions	☐	☐	☐	☐	☐	☐	☐

SKILLS INVENTORY - COMMUNICATION & SOCIAL

Communication and Social Skills

Skill / Activity	I	VP	GP	M	PA	TA	N/A
Greets others	☐	☐	☐	☐	☐	☐	☐
Expresses preferences	☐	☐	☐	☐	☐	☐	☐
Makes choices	☐	☐	☐	☐	☐	☐	☐
Waits / takes turns	☐	☐	☐	☐	☐	☐	☐
Follows directions	☐	☐	☐	☐	☐	☐	☐
Participates in planning	☐	☐	☐	☐	☐	☐	☐
Engages in conversation	☐	☐	☐	☐	☐	☐	☐
Respects boundaries	☐	☐	☐	☐	☐	☐	☐
Handles changes in routine	☐	☐	☐	☐	☐	☐	☐
Self-advocates	☐	☐	☐	☐	☐	☐	☐

TRANSPORTATION PROFILE & CONSENT

☐ Agency-arranged transportation anticipated
☐ Family provides transportation
☐ Public transit training
☐ Rideshare / contracted transport
☐ Individual drives
☐ Transportation not requested

Vehicle accessibility needs
Mobility device securement needs
Behavioral or medical risks during transport
Seating preferences / restrictions
Emergency items carried
Authorized pickup/drop-off persons
Other transportation instructions

I authorize transportation connected to approved services and understand that transportation will be provided only as arranged, authorized, and safely supportable. I will notify the agency promptly of changes affecting transportation safety.

Individual/Applicant Signature	Date

Legal Representative / Guardian, if applicable Signature	Date

EMERGENCY MEDICAL AUTHORIZATION

If I experience a medical emergency while receiving services, I authorize agency staff to call 911, provide first aid within their training, share information needed for emergency treatment, and contact the persons listed in this packet. This authorization does not replace an advance directive, physician order, emergency plan, or legal decision-making document.

- ☐ CPR permitted unless valid order states otherwise
- ☐ Advance directive attached
- ☐ DNR / physician order attached
- ☐ Seizure action plan attached
- ☐ Other emergency medical order attached
- ☐ No special order provided

Special emergency instructions

Hospital preference

Person with authority to consent to treatment

Health insurance company

Member ID

Group number

Individual/Applicant Signature	Date

Legal Representative / Guardian, if applicable Signature	Date

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

Individual name

Date of birth

Person/organization authorized to disclose information

Address / phone / fax

Person/organization authorized to receive information

- ☐ Current ISP and service authorization
- ☐ Medical records and physical examination
- ☐ Medication and allergy information
- ☐ Psychological / psychiatric evaluation
- ☐ Behavior Support Plan / safety plan
- ☐ Educational / vocational records
- ☐ Incident and discharge summaries
- ☐ Billing / eligibility information
- ☐ Other (describe below)

Other records or limits

- ☐ Care coordination
- ☐ Eligibility and intake
- ☐ Service planning and delivery
- ☐ Emergency and safety planning
- ☐ Payment / authorization
- ☐ Other

Expiration date or event

I understand that I may revoke this authorization in writing except to the extent action has already been taken. Information disclosed may be subject to redisclosure as permitted by law. I may receive a copy of this signed authorization.

Individual/Applicant Signature	Date

Legal Representative / Guardian, if applicable Signature	Date

PRIVACY PRACTICES & CONFIDENTIALITY ACKNOWLEDGMENT

The agency protects health and personal information and uses or shares it only as permitted or required for service delivery, payment, operations, safety, oversight, or by law. Individuals may request access, amendment, restrictions, confidential communications, and an accounting of certain disclosures, subject to applicable law and agency procedures.

Acknowledgment

☐ I received or was offered the agency's Notice of Privacy Practices

☐ I understand questions may be directed to the agency's Privacy Officer

☐ I understand signing acknowledges receipt, not agreement with every use or disclosure

Preferred confidential contact method

Restrictions or communication requests

Individual/Applicant Signature	Date

Legal Representative / Guardian, if applicable Signature	Date

INDIVIDUAL RIGHTS & RESPONSIBILITIES

My Rights

- ☐ Be treated with dignity, respect, and privacy
- ☐ Participate in decisions and person-centered planning
- ☐ Receive understandable information about services
- ☐ Choose among available qualified providers
- ☐ Be free from abuse, neglect, exploitation, coercion, and retaliation
- ☐ Receive services in the least restrictive manner
- ☐ Voice complaints and appeal decisions
- ☐ Access records as permitted by law
- ☐ Have cultural, religious, communication, and accessibility needs respected
- ☐ Refuse services or withdraw consent, subject to health and safety requirements

My Responsibilities

☐ Provide accurate and current information
☐ Participate in planning and communicate preferences
☐ Treat staff and others respectfully
☐ Follow agreed safety procedures
☐ Notify the agency of schedule, medical, medication, contact, legal, or funding changes
☐ Protect agency and others' property
☐ Report concerns promptly

Individual/Applicant Signature	Date

Legal Representative / Guardian, if applicable Signature	Date

COMPLAINT, GRIEVANCE & INCIDENT REPORTING

Concerns may be reported verbally or in writing without retaliation. The agency will document, review, respond, and provide escalation information consistent with its policies and applicable requirements. Immediate danger, suspected abuse, neglect, exploitation, or a medical emergency should be reported to emergency or protective authorities as required.

Concern reported by

Relationship

Date/time

How to contact you

Description of concern

Requested resolution

Immediate safety action needed

Agency staff receiving report

Follow-up provided / date

Person Reporting Signature	Date

Agency Representative Signature	Date

PHOTO, VIDEO & MEDIA CHOICE

Choose each option separately. Declining promotional use will not affect eligibility for services.

Use	YES	NO
Identification and internal service records	☐	☐
Private updates to authorized family/representatives	☐	☐
Agency newsletter shared only with authorized recipients	☐	☐
Agency website and social media	☐	☐
Printed brochures, flyers, or advertisements	☐	☐

I understand I may withdraw permission in writing for future use. Withdrawal cannot undo materials already lawfully produced, distributed, or published before the agency received my withdrawal.

Individual/Applicant Signature	Date

Legal Representative / Guardian, if applicable Signature	Date

CONSENT FOR SERVICES

I request and consent to Community Access Individual (CAI) services from It's Not Something, It's Everything, LLC, subject to eligibility, authorization, assessment, acceptance, staffing, and an approved service plan. I understand that services are person-centered, goals are documented in the ISP, and I may participate in planning and review.

- ☐ I consent to CAI services
- ☐ I understand CAG is not currently offered
- ☐ I understand CLS is not currently offered
- ☐ I authorize coordination with my support team as permitted
- ☐ I received information about rights, complaints, privacy, and emergency procedures
- ☐ I understand services may be declined or discontinued according to policy and applicable requirements

People authorized to participate in planning

Special limits on participation or information sharing

Individual/Applicant Signature	Date

Legal Representative / Guardian, if applicable Signature	Date

Agency Representative Signature	Date

REQUIRED RECORDS CHECKLIST

Required / If Applicable	Received	Date	Notes
Completed and signed intake packet	☐		
Current ISP and service authorization	☐		
Medicaid / insurance card copies	☐		
Photo identification / proof of identity	☐		
Guardianship / legal authority documents	☐		
Current physical / medical summary	☐		
Current medication and allergy list	☐		
Emergency medical / seizure / diabetes plans	☐		
Psychological or diagnostic evaluation	☐		
Behavior Support Plan / crisis plan	☐		
Transportation / mobility instructions	☐		
Other records required by authorization or assessment	☐		

Requirements vary by funding source, authorization, age, health status, and assessed risk. Agency staff will identify any additional records needed before services begin.

AGENCY INTAKE REVIEW - OFFICE USE ONLY

Date complete packet received

Reviewed by

Referral source

Requested start date

Funding verified by / date

ISP and authorization verified by / date

Assessment completed by / date

Health and safety review completed by / date

Transportation review completed by / date

Staffing match identified

Proposed service schedule

Outstanding items / conditions

- ☐ Accepted
- ☐ Accepted with conditions
- ☐ Waitlisted
- ☐ Additional information required
- ☐ Unable to accept - needs exceed current scope/capacity
- ☐ Applicant withdrew

Decision rationale and follow-up

Authorized Agency Representative Signature	Date

INITIAL BODILY / INJURY CHECK - OPTIONAL CLINICAL USE

Use only when required by the individual's plan, transition protocol, incident follow-up, or agency procedure. Preserve dignity and privacy. This is not a substitute for medical evaluation.

Individual name

Date

Arrival time

Departure time

Staff completing check

Reason for check

Body area / location	Observation (mark, bruise, swelling, object, complaint)	Present on arrival?	Action taken
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Additional notes and individual statement

Staff / Provider Representative Signature	Date

Receiving Representative, if applicable Signature	Date

ANNUAL PHYSICAL / MEDICAL PROVIDER SUMMARY

Individual name

Date of birth

Date of examination

Primary diagnosis

Allergies

Height

Weight

Blood pressure

Pulse

Temperature

☐ No activity restrictions ☐ Restrictions / accommodations listed below

☐ Communicable disease concern ☐ No communicable disease identified

☐ TB screening attached if required ☐ Follow-up care needed

Current medical conditions and significant history

Diet, swallowing, mobility, lifting, exercise, or community participation restrictions

Recommended follow-up / referrals

Medical Provider Printed Name	Signature / Credentials	Date
Practice Address	Phone / Fax	Next Exam Due