

1. **28 yr. old Female**
2. Address (City/ and/or Zip code) or County: **Girard in Trumbull County**
3. SSA /Referral Contact Information: **Lindsey Ware 330-652-1116 Ext. 104 or LindseyWare@TCBDD.org**
4. Funding Source (Type of waiver or local funding)
 - **I.O. Waiver**
5. Hours Needed (# hours and/or schedule). **96 hours/month; 17 hours during the week and two 7 hours shifts every other weekend so that guardian can work outside of the home. She has the med. add-on rate for HPC.**
6. Anticipated Start Date of Services (Specific date or choice between “Immediate or As soon as available”) **As soon as possible.**
7. Service(s) Needed: (list specific waiver services) **Please see below.**
8. Essential service preferences
 - Important to (which may include personal outcomes) AND Important For (including Supervision needed and/or Information about Alone Time)
 - Description of type of supports needed in various areas, if these are related to “Services Needed” category:
 - *Medical/Medication/Health-**All medications administered through G-Tube.***
 - *Behavioral/Psychiatric -N/A*
 - *Hygiene/ADL/Personal Care-**Needs full assistance with all ADLs and personal care.***
 - *Mealtime/Cooking/Household Maintenance—**N/A, all medications and nutrition given through a G-Tube.***
 - *Money Management-**N/A Guardian handles all of her finances.***
 - *Transportation (including locations and times)—**N/A***
 - *Mobility/Transfers/Positioning-**Full assistance is needed as she is in a wheelchair.***
 - Equipment needs/accessibility needs:
 - *-Has a Wheelchair; Wheelchair seatbelt; Hospital Bed/Bedrails; Hoyer Lift--utilized to transfer her in/out of bed; Wears a smart watch to monitor vitals (guardian purchased to help monitor vitals); wears an abdominal binder at all times--other than when she is bathing; the abdominal binder keeps her tubes tucked away so the tubes don't get pulled on during transfers/ changes/ re-positioning etc.--Wheelchair ramp (currently has a temporary wheelchair ramp at her home in Girard but will be going through the process of a P.T. eval. to get a permanent ramp placed outside her home); Shower chair (otter bathing system) to assist with her bathing. The otter bathing system was purchased by waiver Feb 2020, work completed Sharpe Builders; also uses elbow splints while she is asleep at night as well as palm posey's to help prevent skin breakdown; She requires full assistance to with utilizing these things. In addition, she utilizes an Albuterol*

machine; Palm Posey to help prevent skin breakdowns (Requires natural supports and staff full assistance to utilize); Disposable briefs and wipes; Stethoscope (for g-tube verification); G-Tubes Supplies

- **Communication-She is non-verbal but communicates through facial expressions; she will listen to you and blink when you speak to her. She can also show her preferences if someone holds up two different items to her. She will look towards her choice and stare at it. She will start to make loud noises as this is how she communicates her distress.**

9. *Other Information Individual chooses to share, which may include but is not limited to:*

- Individual Information:
 - **28 yr. old Female**
 - **Diagnosis: Profound Developmental Disability, Cerebral Palsy, Scoliosis, Type 2 Diabetes without complications (no insulin, medications, etc); GERD; Anemia; Vitamin D deficiency; history of seizures, diagnosis of extremity contractures/fractures, and Dysphasia. Congestive Heart Failure.**
 - *Interests: Loves to have visitors and enjoys watching everyone's interactions, Likes to watch cartoons on TV, Enjoys listening to music, Enjoys being read to, enjoys being outside when the weather is warm, and spending time with her family.*
 - *Current living or day program/employment arrangements: **Lives at home with her guardian and attends a day program 5 days/week***
 - *Forensic supports/Criminal background: **N/A***
- Provider Information:
 - *Specific provider skills/knowledge/training requests: **Must have certification to provide G-Tube care.***
 - *Type of provider requested – agency, independent or no preference--**No preference***
- *Location of Services: In Home/Out of Home/Specific area of county: **All services provided inside of the home.***