



## TO MAKE A REFERRAL FOR:

# INDEPENDENT LIVING SKILLS SERVICES

1. The referral process starts with a phone call to FamilyWorks at (415) 419-7144.
2. Please fill in the blank spaces on the Request for Services form.
3. Compile the NEW CLIENT CONSUMER information available. Please include as much information as possible. Here are examples:
  - a) Recent IPP's
  - b) Most recent Psycho-social assessments
  - c) Medical History
  - d) Any other recent evaluations
4. Please include a 25 hour Purchase of Service (POS) for Independent Living Skills training to begin our services. The estimate time for the 25 hour POS is four weeks.
5. Please submit POS by email: [adriana@familyworks.org](mailto:adriana@familyworks.org)

We greatly appreciate your referrals and look forward to working with you.



## INDEPENDENT LIVING SKILLS SERVICES

### Service Request Form

<b>Service Code:</b>	<b>520</b>
<b>Vendor #:</b>	<b>HS0906 for SARC</b> <b>H12286 for GGRC, RCEB &amp; NBRC</b>

**Please complete both pages**  
then email [adriana@familyworks.org](mailto:adriana@familyworks.org)

### Confidential

Consumer's Information
Consumer's Name: _____ UCI #: _____ Date of Birth: ____/____/____ <small style="display: block; text-align: center; margin-top: -10px;">First Name    Middle Name initial    Last Name <span style="float: right;">MM / DD / YYYY</span></small>
<i>Check all that applies about the disability</i>
<input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Epilepsy <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Other _____    IQ: _____ If MR (Mental Retardation) <input type="checkbox"/> Borderline <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Other _____ Ethnicity: _____ Language preferred <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____ Address: _____ City: _____ State: <u>CA</u> Zip: _____ Telephone: (____)____-____ Cell: (____)____-____ Consumer Lives with: <input type="checkbox"/> Partner <input type="checkbox"/> Husband/ Wife <input type="checkbox"/> Independently <input type="checkbox"/> Parents <input type="checkbox"/> Relatives <input type="checkbox"/> is conserved
Other Persons related to consumer
Name: _____ Relationship: _____ <input type="checkbox"/> Live with consumer Tel: (____)____-____ Name: _____ Relationship: _____ <input type="checkbox"/> Live with consumer Tel: (____)____-____ Name: _____ Relationship: _____ <input type="checkbox"/> Live with consumer Tel: (____)____-____ Name: _____ Relationship: _____ <input type="checkbox"/> Live with consumer Tel: (____)____-____
Consumer's Regional Center Information
<b>Case Manager:</b> _____ <b>RC Office:</b> <input type="checkbox"/> GGRC <input type="checkbox"/> NBRC <input type="checkbox"/> SARC <input type="checkbox"/> RCEB Tel: (____)____-____ Cell: (____)____-____ Fax: (____)____-____ E-mail: _____
Consumer's History
<input type="checkbox"/> Domestic Violence <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Child Abuse/Neglect <input type="checkbox"/> Mental Illness Medical Provider: _____ Tel: (____)____-____ Fax: (____)____-____ Doctor/Physician: _____ Tel: (____)____-____ Fax: (____)____-____ Mental Health Provider: _____ Tel: (____)____-____ Fax: (____)____-____ <input type="checkbox"/> Therapist <input type="checkbox"/> Counselor <input type="checkbox"/> Psychiatrist: _____ Tel: (____)____-____

**Confidential Information (cont.)**

Other services consumer is currently receiving:

IHSS    SLS    DP (Day Program)    Other \_\_\_\_\_

Agency Name: \_\_\_\_\_ Worker: \_\_\_\_\_ Service: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Agency Name: \_\_\_\_\_ Worker: \_\_\_\_\_ Service: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Agency Name: \_\_\_\_\_ Worker: \_\_\_\_\_ Service: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Agency Name: \_\_\_\_\_ Worker: \_\_\_\_\_ Service: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Please indicate skills which consumer wishes to enhance/ obtain:**

<input type="checkbox"/> Sex Education	<input type="checkbox"/> Safety skills	<input type="checkbox"/> Transportation Skills
<input type="checkbox"/> Academic growth	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Personal Finance
<input type="checkbox"/> Emotional Regulation	<input type="checkbox"/> Weight	<input type="checkbox"/> Employment
<input type="checkbox"/> Social Skills	<input type="checkbox"/> Exercise	<input type="checkbox"/> Housing
<input type="checkbox"/> Conflict Resolution	<input type="checkbox"/> Hygiene Skills	<input type="checkbox"/> Community Resources
<input type="checkbox"/> Communication Skills	<input type="checkbox"/> Health Maintenance	<input type="checkbox"/> Immigration
<input type="checkbox"/> Stress reduction	<input type="checkbox"/> Home Management	<input type="checkbox"/> Assistance with legal issues

**Comments:**



# **Independent Living Skills Training**

## **Program Goals:**

1. To provide quality and productive independent living to adults and children who have developmental disabilities.
2. To increase the consumer's motivation to enhance their skills and their interaction with their families, work environment and community resources at large.
3. To enhance the consumer's ability to promote their own conceptual, practical, and social development, including but not limited to:
  - a. Providing an appropriate stimulation, recreational and learning environment.
  - b. Providing a safe physical and emotional growth environment.
  - c. Providing social, and recreational interaction with other adults.
  - d. Providing good nutrition, personal hygiene, home, health functional academic and self-management skills.
  - e. Providing optimum cognitive and physical capacities.
4. To train the consumer in effective self-management methods, including anger management, stress reduction and conflict resolution skills
5. To assist with the integration of the consumer into community programs; including increasing the consumers' ability to utilize community physical, emotional, and social support systems in order to foster improved personal development.

## **Location:**

Services take place in the consumer's residence, other natural environments, community facilities in the area served by the Regional Centers.



**Skills assessed, taught, modeled and reinforced during direct services include:**

- Identification and awareness of unique temperament traits
- Self-care skills including personal health and hygiene
- Independent recreation and participation in natural environments
- Household Maintenance
- Nutrition: grocery shopping, menu planning, and meal preparation
- Money management skills/budgeting, including check cashing, and purchasing activities
- Use of public transportation in natural environments.
- Self – advocacy, healthy self-assertion skills training
- Emotional Regulation / Stress-Reduction Skills / Conflict resolution
- Utilization of educational system for self-development / vocational goals
- Nurturing/encouraging pro-social behaviors and expanding social support systems
- Utilization of employment training options
- Use of medical, dental services, and other community health resources
- Community resources awareness (police, fire, emergency, mental health, social services etc.)
- Home and community safety