# A Spark of Possibilities

## Initial Intake Packet

A Spark of Possibilities (SoP) is striving to bridge the gap in services and supports for children and adolescents in Minnesota. We provide a variety of services to meet the needs of many. As of January 1st, 2023, A Spark of Possibilities is licensed 245D under the MN Department of Health to provide specialist services and positive supports. A Spark of Possibilities is working towards providing Licensed Day Camps. We are excited to offer a variety of services including Individualized Home Supports, Respite, and Specialist Services.

**Step 1:** Complete the **entire** Registration Packet

**Step 2:** Submit all required forms

☐ Annual Physical, Immunization List, & Insurance Information

☐ Medication List from Healthcare Provider (possibility of additional medical forms asked of SoP)

☐ Program Guide, Policy Receipt, Payment Agreement,
Photo Release, Medical Emergency, Med/Treat Admin, & Standing Orders - all signed

**Step 3:** Complete an intake with one of our intake specialists/ team, this can be done over the phone, in person or video. This intake will go more in depth about the participant, their medical needs and plan of care.

**Step 4**: Watch your mailbox/ email for confirmation and a welcome letter from A Spark of Possibilities.

**Step 5:** FIRST DAY WITH A SPARK OF POSSIBILITES

17260 217th Ave NW
Big Lake MN 55309
info@spark2hope.org
763-260-0182

## Personal Information

Participant Name: _____ Nick Name: _____
*Legal First Name* *Last* *Middle Initial*

Address: _____
*Steet (include Apt. #, if applicable)* *City* *State* *Zip*
County of Residence: _____
Telephone: (____) _____ Email: _____
Age: _____ Date of Birth: _____Male /Female _____ Height: _____Current Weight: _____
Religious Preference we need to be aware of: _____
Race:

☐White ☐African American ☐First Nation ☐Asian
☐Hispanic ☐Multi Racial ☐Other

How did you find out about A Spark of Possibilities?

☐Advertisements ☐Word of Mouth/Friends ☐Web Search ☐School
☐ Social Worker/Case Manager ☐A Website (please list) or other way: _____
Attend school: ☐ Yes ☐No
If yes, where: _____
Is the Participant employed? ☐ Yes ☐No
If yes, type of work? _____
If attending camp sessions, has the participant ever been to any other camp before? ☐ Yes ☐No
If yes, Camp Name(s) & when _____

**Supervision/Support Needed & Requested Services**

Supervision/ Support needed: ☐High (1:1) ☐ Medium (1:3) ☐ Low (1:5) Choose Service Option

## Contact Information

**Primary Contact #1** **This is where all mail correspondence will be sent**

☐Parent ☐Guardian ☐Other, please specify _____
Name: _____
Address: _____
*Steet (include Apt. #, if applicable)* *City* *State* *Zip*

Phone Number: (____)_____ Email: _____
Employer: _____Work Phone Number: (____)_____

**Primary Contact #2**

☐Parent ☐Guardian ☐Other, please specify _____
Name: _____
Address: _____
*Steet (include Apt. #, if applicable)* *City* *State* *Zip*

Phone Number: (____)_____ Email: _____
Employer: _____Work Phone Number: (____)_____

**Emergency Contact #1** **first point of contact**

Name: _____ Relationship to Participant: _____
Address: _____
*Steet (include Apt. #, if applicable)* *City* *State* *Zip*

Phone Number: (____)_____ Email: _____
Employer: _____Work Phone Number: (____)_____
Does this individual have permission to pick up and transport the participant in the event contact #1 or #2 cannot be reached?
☐Yes ☐No

**Emergency Contact #2** **second point of contact**

Name: _____ Relationship to Participant: _____

Address: _____

*Steet (include Apt. #, if applicable)* *City* *State* *Zip*

Phone Number: (____) _____ Email: _____

Employer: _____Work Phone Number: (____) _____

Does this individual have permission to pick up and transport the participant in the event contact #1 or #2 cannot be reached?

☐Yes ☐No

## Additional Contact Information

**Social Worker/Case Manager**

Name: _____ Agency: _____

Phone: _____ Email: _____

**Support Planner**

Name: _____ Agency: _____

Phone: _____ Email: _____

**Fiscal Management Service (FMS)**

Agency: _____ Contact Name: _____

Phone: _____ Email: _____

**Service/Waiver Program**

Choose Program

Contact˜ ψψψψψψψψψψψψψψψψ_____ψψψψψψψψ

Phone˜ ψψψψψψψψψψψψψψψψψψψψψ__ψψψ

Email˜ ψψψψψψψψψψψψψψψψ_____ψψψψψψψψ

Additional Info˜ ψψψψψψψψψψψψψψ_____ψψψψψψψψψψψ

All correspondence regarding the registration of this application will be sent to primary contact #1 and any other individuals chosen below:

☐Primary Contact #2 ☐Emergency Contact (specify) ☐ FMS/Service or Waiver Program

☐Social Worker/Case Manager ☐Other (specify) _____

## Medical Forms Required

**Annual Physical**

Did the participant have an annual physical within the last year? ☐Yes☐No

-If yes, please attach a copy of the physical along with the most up to date medication list (or send copies to SoP). Both records will be **required** annually to continue in our programs. If SoP staff will be administering medication or treatment to participant, please obtain additional scripts and supplies for use during care at the center.

-If no, participant must be seen by their medical care provider for a physical before joining Spark 2 Hope's Program.

**Immunizations**

Does the participant have all of the recommended vaccines for their age? ☐Yes ☐No

If no, please explain and attach your medical or religious exemption with the registration:

_____

If yes, please include a record with your registration that shows month/year of all immunizations that are recommended for the participant's age. A physician's statement, a government immunization report or a school immunization report can also be accepted. The report MUST show the month/year of last tetanus shot.

**Insurance Information**

Medical Assistance #: _____ Primary Insurance Provider Name: _____

Policy #: _____ Policy Holder's Name: _____

(or send a copy of the insurance card to SoP)

## Health Information

**Primary Doctor**
Name: _____ Clinic: _____
Address: _____ Phone Number: (____) _____
*Street Number* *City/State/Zip*

**Mental Health Provider**
Name: _____ Clinic: _____
Address: _____ Phone Number: (____) _____
*Street Number* *City/State/Zip*

**Dental Provider**
Name: _____ Clinic: _____
Address: _____ Phone Number: (____) _____
*Street Number* *City/State/Zip*

Has the participant been hospitalized within the last 12 months? ☐Yes ☐No
If yes, please explain _____
_____

Has the participant been treated in an Emergency Room within the last 12 months? ☐Yes ☐No
If yes, please explain _____
_____

Please list any operations, serious injuries, or recurring illnesses: _____
_____

**Diagnosis/Disability/Condition**
**REQUIRED** Primary Diagnosis (medical, no abbreviations): _____
Secondary Diagnosis: _____

Please indicate any additional diagnosis/disabilities/conditions that apply

**Neurodevelopmental**

☐Angelman Syndrome
☐Autism Spectrum Disorders
☐Cerebral Palsy
☐Down Syndrome
☐Global Developmental Delays
☐Fetal Alcohol Spectrum
☐Sensory Processing Disorder
☐Prader-Willi Syndrome
☐Rett Syndrome
☐Williams Syndrome
☐ADHD
☐ Inattentive
☐ Hyperactive
☐ Combine Type
☐Intellectual disabilities
☐ Mild
☐ Moderate
☐ Severe
☐ Profound

☐Other: _____

**Neurological** **Protocols needed on file*

☐Anxiety
☐Bipolar
☐Borderline Personality Disorder
☐Depression
☐Dissociative Disorders
☐Eating Disorders
☐*Epilepsy/ Seizure Disorders
☐Neurobehavioral Disorder associated with Prenatal Alcohol Exposure
☐Obsessive Compulsive Disorder
☐Oppositional Defiant Disorder
☐Post-Traumatic Stress Disorder
☐Reactive Attachment Disorder
☐Traumatic Brain Injury
☐Tourette Syndrome
☐Other: _____

**Pulmonary (Lung)** **Protocols needed on file*

☐Asthma
☐Aspiration pneumonia – history
☐Congenital lung issues
☐Cystic Fibrosis
☐Respiratory Failure – history
☐*Tracheostomy
☐Other: _____

**Cardiac (Heart/ Blood)**

☐Sickle Cell Anemia
☐Anemia
☐Bleeding Disorders -If yes, describe: _____
☐Heart Disorders- If yes, describe: _____
☐Other: _____

**Muscular & Neuromuscular** **Protocols needed on file*

☐Amputee
☐Muscular Dystrophy
☐*Mobility equipment
☐*Orthopedic appliances
☐Paraplegic
☐Quadriplegic
☐Spasticity
☐Spasms
☐Spina Bifida
☐Other: _____

**Sensory**

***Vision impairment***

☐Blind
☐Vision impairment- If yes, please explain_____
☐Wears glasses
_____
☐Yes
☐No

***Hearing impairment***

☐Has hearing device
☐Yes: explain _____
☐Deaf
☐Hearing impaired
☐No

***Oral sensory***

☐Oral sensory input needs- If yes, explain: _____
☐Oral aversion
☐PICA

***Specialized Care Needs** **Protocols needed on file*

☐*Catheter
- ☐ Indwelling
- ☐ In and out on a schedule
- ☐ Suprapubic

☐*Dysautonomia
- ☐ Temperature
- ☐ Respiration
- ☐ Heart Rate
- ☐ Blood Pressure

☐*Diabetes
- ☐ Type 1
- ☐ Type 2

☐*Colostomy

☐*Feeding Tube
☐*Other: _____

**Allergies**

☐Food: _____
☐Plants: _____
☐Insects: _____
☐Medicines: _____
☐Environment: _____
☐Animals: _____
☐Other:_____
Reaction type:

☐Anaphylaxis ☐Rash/Hives ☐Upset Stomach
☐Other: _____

**Seizures**

Does the participant have a seizures/seizure disorder? ☐Yes ☐No
Type of Seizures:

☐ Grand Mal
☐ Absence (loss of consciousness)
☐ Myoclonic/Clonic (jerking)
☐ Tonic (muscle stiffness//rigidity)
☐ Atonic (loss of muscle tone)
☐ Other, describe: _____

Frequency of seizures: _____
Duration of seizures: _____
Date of last seizure: _____
Are seizures controlled with medication? ☐Yes ☐No
When to notify emergency contact? ☐Every time
☐Over 5 Minutes
☐Other _____

Please describe what the participants seizures looks like (including behavior before, during and after event):

_____
_____
_____

## Behaviors

**Behaviors**

Does the participant display any behavioral issues? ☐ Yes ☐ No

If yes, please check all behaviors below:

☐Self-Injury ☐Spitting ☐Biting
☐Property Destruction ☐Elopement ☐Yelling
☐Inappropriate Language ☐Not Following Directions ☐Sexual Acting Out
☐Physical Aggression: (kicking/hitting/punching)
☐Other: _____

If any behaviors above are checked, please describe when these behaviors typically occur, what they look like, how long they last:

_____
_____
_____
_____
_____

Please describe any behavior triggers:

_____
_____
_____

When do you see most behaviors occurring?

☐Hungry ☐Uncomfortable ☐Hurt
☐Bored ☐Dysregulated ☐Unknown
☐Other: _____

How often do these behaviors occur?

☐Seldom (1x/month) ☐ Often (1x/week) ☐Frequently (More than 1x/week) ☐Daily

What behavioral indicators might exist that show the person is in distress before a behavior exists?

_____
_____

Please explain what the behavior typically looks like, what redirection is done, and what the typical response is to redirection:

_____
_____

What are effective tools for de-escalation of the behavior?:

_____
_____
_____

## Functioning and Communication

**Communication & Social Skills**

Can the participant communicate wants and needs effectively to others? ☐Yes ☐No

How does the participant communicate? Please check all that apply

☐Verbally ☐ Sign Language ☐Electronic Device
☐Gestures ☐Other _____

Can the participant understand/respond to questions? ☐Yes ☐No

Does the participant have difficulty understanding the communication of others? ☐Yes ☐No

Is the participant able to:

Read ☐Yes ☐No
Write ☐Yes ☐No

Can the participant indicate pain? ☐Yes ☐No

Please explain how:

_____

How does the participant adjust to new situations and new people?

_____

Does the participant have any routines that are significant for A Spark of Possibilities staff to be aware of? ☐Yes ☐No
If yes, please explain:

Are transitions (moving from one activity/place to another) a challenge for the participant? ☐Yes ☐No
If yes, please explain and include details on strategies that are successful:

***Communication Impairments***

☐Limited functional communication
☐Receptive communication
☐Expressive communication
☐No functional communication
☐Communication Augmentations/ Alternatives
Notes: _____
_____

**Special Equipment and Mobility**

Participant is:
☐Ambulatory/Can walk independently
☐Semi-Ambulatory/Can walk with assistance
☐Non-Ambulatory

***Adaptive Equipment:***

Please check all special equipment that the participant will use and will be brought to A Spark of Possibilities

☐Glasses ☐Hearing Aids ☐Dental Retainers/Devices ☐Adaptive Utensils
☐Gait trainer/ ☐Walker ☐Crutches ☐ Orthotic Braces/ splints ☐Prostheses
☐Wheelchair (☐ Electric/ ☐ Manual/ ☐ Stroller) ☐Other: _____
Please describe participant ability to operate wheelchair (if applicable): _____
_____
Assistance in transferring? ☐Yes ☐No
What type of transfer is used? _____ Mechanical lift ☐Yes ☐No
Require range of motion exercises? ☐Yes ☐No *If yes, please attach copy of exercises*
Special Instructions/Other Information: _____
_____

**Eating**

Does the participant require special feedings (i.e. G-Tube, specialized diet)? ☐Yes ☐No
Please explain: _____
Special dietary needs (please be specific):
_____
_____

Can the participant feed themselves? ☐Yes ☐No
Please explain: _____
_____

Participant appetite is: ☐Good ☐Average ☐Poor
How many glasses of water does the participant typically drink per day? _____
Food Likes: _____
_____
Food Dislikes: _____
_____

***Please provide needed utensils and supplies***

**Toileting and Hygiene**

Does the participant have bladder control? ☐Yes ☐No
Does the participant have bowel control? ☐Yes ☐No
Does the participant need reminders/prompting? ☐Yes ☐No
Does the participant use the toilet on a schedule? ☐Yes ☐No
If yes, please provide schedule _____
_____
Does the participant need assistance during toileting? ☐Yes ☐No
If yes, please explain type of assistance needed _____
_____
Do you have a Bowel Program? ☐Yes ☐No
*Bowel program medications must be included on the Medication List for Medication Administration at A Spark of Possibilities*
☐ I have a different bowel program (please explain): _____
If appliable, is the participant independent in menstrual care? ☐Yes ☐No

Does the participant use the following (check all that apply)?
☐Urinal
☐Bedpan
☐Commode
☐Intermittent Catheter
☐Incontinent Products *If yes, please be sure to supply plenty of products to accommodate the entire day*
☐Menstrual Products *If yes, please be sure to supply plenty of products to accommodate the entire day*
Can the participant wash and dry hands ☐Independently ☐Needs Help
Explain further: _____

## Recreation and Activities

Please list the activities (sports, hobbies, etc.) the participant currently participates in: _____
_____
Does the participant have any adaptive equipment to assist with participant in activities? ☐Yes ☐No
If yes, please explain: _____
_____
Does the participant have any limitations to being outside in the sun/heat for approximately 30 minutes at a time?
☐Yes ☐No
If yes, please explain _____
_____
Please list any activities the participant does not like:
_____
_____
What are the participants favorite things to do or learn about?
_____
_____
Are there any activities the participant should be exempt from for health reasons? ☐Yes ☐No
If yes, please explain: _____

**Animal Room**

Does the participant have any allergies to animals? ☐Yes ☐No
If yes, please explain _____
_____
Does the participant have any fear of animals? ☐Yes ☐No
If yes, please explain _____
_____

**Sports and Games**

What sports has the participant participated in previously? _____
Does the participant participate well in group activities? ☐Yes ☐No
If no, please explain _____
_____
Please list any indoor games/activities the participant particularly likes:
_____
_____

**Arts and Crafts**

What types of crafts or art (drawing painting, making bead necklaces, etc.) does the participant enjoy?
_____
_____
Are there any behaviors or limitations that would prevent the participant from participating in arts and crafts?
☐Yes ☐No
If yes, please explain _____
_____

Reviewed By: _____ Date: _____
Staff Signature