# NEW BEGINNINGS ENTERPRISES, INC.

## Lifestyles Needs and Preferences Assessment

Name:________________________________________ Date Completed:____________________

Current Living Status: ❒ Alone ❒ Family ❒ ICF-MR ❒ State Hospital

❒ Spouse/Friend ❒ Other__________________________

Where would I like to live? (where, what type of housing,alone or with someone, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What supports do I need to maximize my ability to use these services?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What would I like to receive training on during this program?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

During the day, I would be interested in the following programs (please number in order of preference):

_______ Adult Day Care
_______ Adult Life Skills
_______ Work Activities
_______ Supported Employment
_______ Supported Retirement (age 45 and older)
_______ Other______________________________

What supports do I need to maximize my ability to use these services?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What would I like to receive training on during this program?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you have any relatives in the area?____________________________________________

Do you have contact with your relatives? How often?_____________________________

________________________________________________________________________

What are your plans or goals for the future?_______________________________________

________________________________________________________________________

What do you like to do for fun?_________________________________________________

________________________________________________________________________

Is there anything you would like to do that you are not doing now?___________________

________________________________________________________________________

Other Services Needed:

| | | | |
|---|---|---|---|
| _______ | Transportation | _______ | Counseling |
| _______ | Case Management | _______ | Wellness Monitoring |
| _______ | Personal Assistance (Supportive Home Care) | _______ | Medical Alert |
| _______ | Physical Therapy | _______ | Home Modification |
| _______ | Occupational Therapy | _______ | Vehicle Modification |
| _______ | Speech Therapy | _______ | Budgeting Assisting |
| _______ | Special Health Care Needs | _______ | Nursing Services |
| | (insulin shots, positioning, special diet, special equipment, or adaptive devices) | | |

______________________________________________ ________________

Signature of Applicant Date

______________________________________________ ________________

Signature of Guardian Date

______________________________________________ ________________

Signature of CDDO Representative Date