MVLE, Inc.
7420 Fullerton Road, #110, Springfield Virginia 22153
Tel: (703) 569-3900; Fax: (703) 569-3932

APPLICATION FOR VIRTUAL LEARNING SERVICES

Applicants please include: *Most current* psychological evaluation, vocational evaluation, current resume, and if applicable, current IEP and behavior intervention plan	
Name:	**Date:**
Address:	**Residential Contact (*if other than applicant*):**
	Tel. #:
Email:	**Signature:**
Name of person completing form:	**Referral Source:**
Reason for Applying:	
☐ SSI ☐ SSDI ☐ Savings Account ☐ Able Account ☐ Other (please list)	
Funding Source/Eligibility (Check all that apply): ☐ Fairfax/Falls Church CSB ☐ Alexandria CSB ☐ Arlington CSB ☐ Loudon CSB ☐ DD Waiver	
Type of service desired: ☐ Virtual Group Day Support Services ☐ Virtual Pre-Employment Training	
Primary diagnosis:	
Secondary diagnosis:	
Chronic Medical Conditions:	
Other needs not listed above (*i.e., mental health, physical, communication, hearing, visual, sensory, dietary*):	

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EDUCATION/VOCATIONAL HISTORY **(*List most recent first*)**			
Education/Training Program Name and Address	Program	Start Date	End Date

EMPLOYMENT HISTORY **(*List most recent first*)**			
Employer Name and Address	Position/Duties	Start Date	End Date
Reason(s) for leaving: (Please be specific. Include any issues while on this job).			
Employer Name and Address	Position/Duties	Start Date	End Date
Reason(s) for leaving: (Please be specific. Include any issues while on this job).			
Employer Name and Address	Position/Duties	Start Date	End Date
Reason(s) for leaving: (Please be specific. Include any issues while on this job).			

INTERESTS, TALENTS, HOBBIES, AND GOALS

Signature of Applicant: _____ **Date:** _____

Person completing form: _____ **Date:** _____

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Virtual Individual Profile

Updated On:

IDENTIFYING INFORMATION		
Full Name:	Date of Birth:	Admission date:
Address: (number and street)	Telephone #:	Email:
City, State, Zip Code	Point of Contact:	
Guardianship status: ☐ Own ☐ Has guardian ***Please provide copy of guardianship document***	P.O.C. Telephone # (if different):	
Social Security Number:	Medicaid Number (if applicable):	Marital Status:

PARENT/LEGAL GUARDIAN INFORMATION	
Name(s):	Relationship:
Address:	Telephone # (W):
	Telephone # (H):

EMERGENCY CONTACTS	
List below person who MUST be contacted, in the order of contact. If parent/guardian, enter below in proper order.	
Name(s):	Relationship:
Address:	Telephone # (W):
	Telephone # (H):
Name(s):	Relationship:
Address:	Telephone # (W):
	Telephone # (H):
Name(s):	Relationship:
Address:	Telephone # (W):
	Telephone # (H):

MEDICAL INSURANCE INFORMATION							
Medical Insurance Company:				POLICY #:			
	MEDICAID		MEDICARE		CHAMPUS		ID#:

EMERGENCY MEDICAL AUTHORIZATION	
Purpose: to facilitate emergency treatment should the individual become ill or injured at work, en-route to the job site or when participating in an activity organized and/or authorized by the agency.	
Preferred Hospital:	
Address:	Telephone #:
	Alternative Telephone #:
Preferred Physician:	
Address:	Telephone #:
	Alternative Telephone #:
Preferred Dentist:	
Address:	Telephone #:
	Alternative Telephone #:

1. In the event that, in the judgment of MVLE/employer staff, emergency medical treatment is necessary, I hereby give my consent for the transfer to the above hospital, or other reasonably accessible hospital.
2. In the event that the above designated practitioner(s) is/are not available, I hereby give my consent for the utilization of emergency medical personnel.

Note: This authorization does not cover major surgery unless the opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery. Such opinions must be obtained prior to the performance of such surgery.

Employee's Signature:	Date:
Legal Guardian Signature:	Date:
MVLE Staff Signature:	Date:

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CURRENT MEDICAL INFORMATION
Date of Current Physical: (please attach a copy)
Allergies (PAST & CURRENT):
Substance Abuse:

MEDICATION/DRUGS (including prescription, non-prescription, nicotine, and alcohol):				
Medication/Drug	Dosage	Frequency/Time	Purpose	Start/End Date

SIGNIFICANT MEDICAL CONDITIONS/PROBLEMS: (IE: Sight/hearing/speech, seizures, arthritis, diabetes, phobias, communicable diseases – Please mark all that apply)
☐ Diabetes ____Seizures ____Vision ____Hearing ____Arthritis ____Falls Risk ☐ Paralysis
☐ Dietary (Please indicate type): _____
☐ Cerebral Palsy ☐ Cancer ☐ Asthma ☐ COPD ____ ☐ Colostomy Care _____Ostomy Care
☐ Heart Disease ☐ Thyroid Disease
_____Other: (Please indicate): _____
Past Serious Illnesses, Injuries and Hospitalizations:
Does the individual have an Advanced Directive (DNR)? _____Yes _____No
If yes original medical documentation must be filed with the MVLE nursing office.

MVLE Staff signature confirms that all the information is accurate as reported by the individual, parent/guardian, or case manager. The Employee Profile form is to be reviewed during each annual evaluation to ensure the information is current and appropriate. Changes are to be completed on another Employee Profile form. A MVLE staff and individual or guardian's dated signature will confirm a renewal of the individual profile form without changes.

_____	_____	_____
MVLE Staff Signature	Employee Signature	Date
_____	_____	_____
MVLE Staff Signature	Employee Signature	Date
_____	_____	_____
MVLE Staff Signature	Employee Signature	Date

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MVLE Vocational Functional Analysis Survey

This survey has been adapted from the "Level of Functioning Survey" that has been provided by DMAS. Please complete to the best of your ability.

Name of Person Surveyed: _____

Definition of Terms:

- "Never" means that the behavior does not occur.
- "Rarely" means that the behavior occurs quarterly or less.
- "Sometimes" means that the behavior occurs once a month or less.
- "Often" means that the behavior occurs 2-3 times a month.
- "Regularly" means that the behavior occurs weekly or more.

1. Health Status: How often is care or supervision by a licensed nurse or person certified in medication administration required for the following? (Please select from the drop down menu)

- Medication administration and/or evaluation for effectiveness of a medication regimen..... Never
- Direct services such as care for lesions, dressings, and treatments (not including shampoos, foot powder, etc.) ..... Select one:
- Seizure control and/or monitoring ..... Select one:
- Teaching diagnosed disease and diet control/care, including diabetes ..... Select one:
- Management of care of diagnosed circulatory or respiratory problems ..... Select one:
- Motor disabilities which interfere with all activities of daily living such as dressing, mobility, toileting, etc..... Select one:
- Observation for choking or aspiration while eating, drinking ..... Select one:
- Supervision of use of adaptive equipment, i.e. special spoons, braces, etc .... Select one:
- Observation for nutritional problems (i.e. undernourishment, swallowing difficulties, obesity) ..... Select one:
- Has a diagnosis of a chronic disease and has been in an institution for 20 years or more..... Select one:

2. Communication (Please select from the drop down menu)

- Indicate wants by pointing, vocal noises, facial expressions or signs ..... Select one:
- Use simple words, phrases, short sentences with or without the use of communication device ..... Select one:
- Ask for at least 10 things using appropriate names with or without the use of a communication device ..... Select one:
- Understand simple words, phrases or instructions containing prepositions such as on, in, or behind ..... Select one:
- Communicate in an easily understood manner ..... Select one:
- Identify self, place or residence and significant others with or without the use of a communication device ..... Select one:

- Respond to auditory stimuli (may use hearing aid) ..... Select one:

3. Task Learning Skills: How often does this individual perform the following activities? (Please select from the drop down menu)

- Pay attention to purposeful activities for 5 minutes..... Select one:
- Stay with a 3-step task for more than 15 minutes..... Select one:
- Tell time to the hour and understand time intervals ..... Select one:
- Count more than 10 objects ..... Select one:
- Do simple addition, subtractions ..... Select one:
- Write or print 10 words ..... Select one:
- Discriminate shapes, sizes or colors ..... Select one:
- Name people or objects when describing pictures ..... Select one:
- Discriminate between "one", "many" and "few" ..... Select one:

4. Personal/Self Care: Can this individual, without assistance, currently perform the following tasks? (Please select from the drop down menu)

- Perform toileting functions: i.e. maintain bladder and bowel continence, clean self, etc ..... Select one:
- Perform eating/feeding functions: i.e. drink liquids and eat with a spoon or fork, etc..... Select one:
- Perform bathing functions: i.e. washes hands after performing eating/ toileting ..... Select one:
- Dress upon entering/exiting building ..... Select one:
- Dress self completely after performing toileting, i.e. including fastening and putting on clothes..... Select one:

5. Mobility: Can this individual, without assistance, currently perform the following tasks? (Please select from the drop down menu)

- Move (walking, wheeling) around environment..... Select one:
- Stand to a sitting position ..... Select one:
- Sit without support ..... Select one:
-Use one or both arms to independently carry a large object ..... Select one:
- Use either hand to pick up a small object ..... Select one:
- Walk up and down stairs with rails ..... Select one:
- Walk up and down curbs ..... Select one:

6. Behavior: How often does this individual perform the following behaviors? (Please select from the drop down menu)

- Engage in self-destructive behavior..... Select one:
- Threaten or do physical violence to others ..... Select one:
- Throw things, damage property, have temper, outbursts..... Select one:
- Respond to others in a socially unacceptable manner without undue anger, frustration or hostility ..... Select one:

7. Community Living Skills: Can this individual, without assistance, currently perform the following activities? (Please select from the drop down menu)

- Prepare lunch at mealtime ..... Select one:
- Take care of personal belongings ..... Select one:
- Add coins of various denominations up to one dollar ..... Select one:
- Use the telephone to call home, doctor, fire, police ..... Select one:
- Recognize survival signs/words: i.e. stop and go traffic lights, police, men or women restrooms, danger, etc... Select one:
- Refrain from exhibiting unacceptable social behavior in public ..... Select one:
- Safety navigate in offsite, community-based, multi-level settings (elevators, escalators) ..... Select one:
- Make minor purchases, i.e. candy, soft drink, etc. ..... Select one:

Person Completing Evaluation:

Name (Please Print)	**Relationship to Individual**
Signature	**Date (Month/Day/Year)**

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LEARNING STYLE PROFILE

Name:	Medicaid #:	Report Date:
Completed by (*please include title, agency*):		Signature:

<u>Directions</u>: Please comment on all of the following topics using the guidelines provided in the parentheses. You may use the reverse side should you require more space.

COMMUNICATION *(Types of communication or combination of these which enable the learner to learn a new task in the most efficient manner: physical (proprioceptive, kinaesthetic, tactile (hand-over-hand, use of jigs), visual (sign language, gestures, pictures/symbols, modelling/demonstration), auditory (verbal) -- level of understanding of basic concepts/directions)*

ENVIRONMENTAL CONDITIONS *(Optimal staff ratio, peer grouping, room size, temperature, noise level, lighting, etc...)*

REINFORCERS / MOTIVATORS *(Optimal reinforcement frequency and type - e.g., music, praise, points, quotas, self-motivation, etc...)*

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INDIVIDUAL APPROACH TO TASK *(Response to new stimuli (attention level, fear, acclimation rate), attention to task (new and old), distractions, processing of information, motivation, dependence on supervision, prompts, and rewards, amount of practice necessary before spontaneity of task, degree of spontaneity, problem solving skills, etc...)*

RETENTION AND GENERALIZATION *(application of skill to new situation, recall over time, frequency of review for maintenance, etc.)*

OBSTACLES TO PROGRESS *(interfering behaviours, medical problems, personal/social adjustment, physical impairments, use of adaptive equipment, etc.)*

SELF-ADVOCACY: *(Check all that apply)*

- ☐ Requests assistance when needed
- ☐ Expresses needs
- ☐ Identifies disability in functional terms
- ☐ Appropriately assertive – internalises frustrations
- ☐ Accesses resources
- ☐ Other (describe)

COMMUNITY ACCESS: *(Check all that apply)*

- ☐ Drives
- ☐ Uses public transportation with support
- ☐ Uses recreational facilities
- ☐ Uses community resources with support
- ☐ Other (describe)

WORKER CHARACTERISTICS: *(Check all that apply)*

☐ Dependable	☐ Accurate	☐ Communicates appropriately
☐ Motivated to work	☐ Demonstrates appropriate speed	☐ High quality of work
☐ Persistent	☐ Adaptable to change	☐ Maintains stamina
☐ Independent worker	☐ Appropriate problem solving skills	☐ Exhibits self-awareness

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Behavior Intake Questionnaire

In order to better assist MVLE staff in developing an appropriate support plan to meet this individual's needs, it is critical to have complete and up-to-date information as part of our intake process. This includes a full description of the individual's behavioral repertoire, both past and present. The questionnaire below may be completed individually or collaboratively by those involved in the person's daily habilitation.

Applicant's Name _____ **D.O.B.** _____

Referral Source _____ **Primary Diagnosis** _____

Date of Report _____ **Medical Condition(s)** _____

Reporter's Name _____ **Reporter's Signature** _____

Relationship to Applicant _____

Length of Time Providing Service/Care (# months, years) _____

Applicant's Behavioral Challenges (please indicate the frequency, severity of the behavior by answering the following:

1. Has the individual **ever** demonstrated **aggression toward others? No_____ Yes_____**

2. If **"Yes," when** was the **last incident? Date at: home_____ school_____ work_____ other_____**

   a. **Toward** (check all that apply): **staff_____ peers_____ family members_____ others (i.e., in the community)_____**

3. Please describe **how aggressive behavior** is **typically performed** in **observable** terms (i.e., hits with an open palm, pinches, pulls hair, etc.):

_____
_____
_____

   a. **Average frequency** (i.e., # times/day/week/month): _____

   b. **Average intensity** (i.e., mild=no injury moderate=causes bruising/abrasion high=causes open wounds/broken bones): _____

4. Has the individual **ever** demonstrated **self-injurious behavior?: No_____ Yes_____**

   a. If **"Yes," when** was the **last incident? Date at: home_____ school_____ work_____ other_____**

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5. Please describe **how self-injurious behavior** is **typically performed** in **observable** terms (i.e., bangs head on walls/objects, picks at skin, hits side of face with closed fist, etc.):

_____

_____

_____

a. Average frequency (i.e., # times/day/week/month): _____

b. Average intensity (i.e., mild=no injury moderate=causes bruising/abrasion high=causes open wounds/broken bones): _____

6. Has the individual ever demonstrated any **other disruptive, interfering or dangerous behaviors?:** **No_____ Yes_____**

a. If **"Yes," when** was the **last incident? Date at: home_____ school_____ work_____ other_____**

7. Please describe any **other disruptive, interfering or dangerous behaviors** that the individual demonstrates or has demonstrated in the past (i.e., elopement, property destruction, opposition, tantrum) in **observable** terms:

_____

_____

_____

a. Average frequency (i.e., # times/day/week/month): _____

b. Average intensity (i.e., mild=minimal disruption/no damage moderate=temporarily disrupts immediate environment/reparable damage high=major disruption/irreparable damage):
_____

8. Do the behaviors (i.e., property destruction, aggression, self-injurious behavior, etc.) typically occur in a predictable **sequence** or **cluster**? If so, please explain:

_____

_____

9. When do(es) the behavior(s) usually occur? [State specific antecedent(s) for each behavior noted above (i.e., self-injurious behavior follows the presentation of an instructional demand, tantrum follows denied access to a desired item/activity, etc.)].

_____

_____

10. What is the **most effective** method to **interrupt** or **redirect** the behavior(s) to **a positive alternative?**

_____

_____

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11. Other Pertinent Observations/Comments

_____
_____
_____

Targeted Service _____

Supports Needed (i.e., staffing patterns/ratios, environmental modifications, assistive technology, etc.)

_____
_____
_____