

The Continuum Admission Forms Packet

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Instructions

1. Please print out the forms and fill them out completely. Print legibly.
2. Please feel free to call for assistance. Ask for Judy Ross, Kim Edwards or J Matthews. We will be happy to contact your insurance company for benefits, eligibility and authorization requirements.
3. Family history forms are required only if the client is receiving all three therapies; Speech, Occupational and Physical Therapy. We ask that a family member or close friend assist the client in completing this form. This information is extremely helpful in providing the most effective treatment. In addition, it will help us provide activities that are of interest to the client. Some of the questions may not pertain to your family member, if this is the case please write "DNA" (does not apply) in the space.
4. **After completing the forms, you may fax, mail or bring them to the address below.**
5. Thanks for your cooperation. This information will be kept confidential.

The Continuum
3700 Grant Drive, Suite A
Reno, NV 89509
775-829-4700
775-829-4710 (fax)
medrecords@thecontinuum-reno.com
sched@thecontinuum-reno.com
kimberlyedwards@thecontinuum-reno.com



The Continuum Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding privacy practices.

This Notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health information is very important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow privacy practices that are described in this Notice while it is in effect unless we replace it.

We reserve the right to change our privacy practices, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operation. For example:

Treatment: We use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing and competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect the use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health to a family member, friend or other person to the extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters.)

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you request copies, we will charge you \$.10 for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation as to how payments will be handled under the alternative means or location you request.

Amendment: you have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S.. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon your request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: JoAnn Ross-Blake
Telephone: 775-829-4700 Fax: 775-829-4710
Address: 3700 Grant Dr. Ste. A
Reno, NV 89509
Email:joannrossblake@thecontinuum-reno.com

The Continuum Financial Policy and Guidelines

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please consider that payment is a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. _____
- In special instances, we may accept assignment of insurance benefits, however you are ultimately responsible for the bill. _____
- All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. _____
- Fees for these services, along with unpaid deductibles and copayments are due at the time of treatment. _____
- It is your responsibility to understand copayments, deductibles, and co-insurance and to be aware and inform The Continuum of any changes in your policy. _____
- If the insurance company does not pay in full within forty-five (45) days, we may require you to pay the balance due with cash, check or credit card. _____
- Unless an appointment is canceled at least twenty-four (24) hours in advance, you may be charged for that appointment at the rate of a normal office visit. Please call if you have to reschedule. _____
- I am aware that I may be treated in an open area and not in a private treating room. _____
- I am aware that I am not to repeat any patient information that does not pertain to me that I may hear while being treated in an open treatment room. _____
- A patient has the right to confidentiality whether medical, financial, and/or personal. _____
- A patient has the right to understand all treatment and treatment options. _____
- A patient has the right to receive information contained in medical records. _____
- A patient has the right to understand all billing and fees. _____
- A patient has the responsibility to provide current, total, and accurate medical history information. _____
- A patient has the responsibility to provide total and accurate billing information. _____
- A patient has the responsibility to comply with medical advice and if non-compliant to medical advice, the patient agrees to advise their physician. _____
- A patient has the responsibility to understand and abide by The Continuum policies. _____
- A patient has the responsibility to ask questions if they do not understand any of their rights and responsibilities. _____
- I have received a copy of The Continuum Financial Policies and Guidelines. _____
- I have received a copy of The Continuum's Notice of Privacy Practices. _____

Patient Name

Date

Patient Signature (Parent or Guardian if child is a minor)

Billing Coordinator
Chris Werner

Date

Patient's Name:

Medicare #(HICN):

Advance Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for -**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ _____**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payment I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or

through any other insurance that I have. I understand I can appeal Medicare's decision. **Option 2.**

NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

To Our New Clients:

Welcome to The Continuum! Our goal is to provide our clients with the best therapy program in the most pleasant environment.

If you are receiving two or more therapies you will have a case manager who will help to coordinate your program. If you are receiving one therapy, your primary therapist will also serve as your case manager. Any therapeutic problems or concerns should be addressed with the case manager or the coordinator. Financial concerns should be addressed with our billing coordinator or myself.



We believe that the most effective rehabilitation goals are achieved when we work together as a team. You determine your needs and how we can help you. We work together through family conferences, family participation, and assistance with individually designed home programs.

Although the primary therapist and rehabilitation tech will perform most of the therapy, you may occasionally have a different therapist due to illness or vacation leaves. Since we all work as part of a team the substituting therapist will continue with the written program to ensure continuity.

When appropriate, your physician will be sent updated reports explaining the program and progress toward goals.

Most sessions are 50 minutes (clinical hour). This schedule gives the therapist time to prepare for the next client.

Sessions for children may be shorter depending on the stamina and attention span of the child. Your therapist will inform you of the length of the sessions. If you leave during a session it is important that you return 20 minutes before the hour (e.g. 10:40 AM if the therapy started at 10:00 AM), as the therapist may want to discuss the program or you may have questions to ask.

It is very important that all appointments are kept. This provides for consistency of the therapy program and the best opportunity for a successful outcome. Also, it is important that appointments be kept as insurance companies may review documentation and question appropriateness of a rehabilitation program if appointments are frequently canceled. If you must cancel an appointment please contact us as soon as possible. We may be able to reschedule therapy at a different time or day.

If more than three therapy sessions are not attended, your case manager will meet with you to determine if the therapy program should be continued.

When the therapy program is completed you will receive a customer survey form. Completing this form as honestly as you can is valuable in helping us to improve our services or knowing we have met your expectations.

Again, welcome. You are the reason we are here and you are very important to us!

Sincerely,

Diane Ross
Coordinator

Your case manager is _____

The Continuum

NEW PATIENT INFORMATION SHEET
(PLEASE PRINT)
PATIENT

PATIENT NAME _____
LAST FIRST MI

PHYSICAL ADDRESS _____
STREET CITY STATE ZIP

BILLING ADDRESS _____
(IF DIFFERENT) STREET CITY STATE ZIP

Please indicate if you want all correspondence from The Continuum sent in a sealed envelope marked "Confidential" Yes () No ()

PHONE NUMBER () - () - () -
HOME CELLULAR WORK

Please indicate the telephone number where you want to receive calls about your appointments, billing questions, or other healthcare questions _____. Please note that we will use this number to leave messages regarding the above if there is no answer.
I am fully aware that a cell phone is not a secure and private line.

DATE OF BIRTH ____/____/____ SSN ____-____-____ MALE () FEMALE ()
PLEASE USE 4-DIGIT YEAR PATIENT SOCIAL SECURITY NUMBER

IS THE PATIENT A CHILD () UNMARRIED () MARRIED () WIDOWED ()

PATIENT EMPLOYER _____

PARENT/SPOUSE/GUARDIAN

NAME _____ SSN ____/____/____
EMPLOYER _____

NAME ADDRESS

INSURANCE INFORMATION

PRIMARY
INSURANCE COMPANY _____
NAME STREET, CITY, STATE, ZIP
INSURED'S NAME _____ INSURED'S DOB ____-____-____
PLEASE USE 4-DIGIT YEAR
ID NUMBER _____ GROUP NUMBER _____

SECONDARY

INSURANCE COMPANY _____
NAME STREET, CITY, STATE, ZIP
INSURED'S NAME _____ INSURED'S DOB ____-____-____
PLEASE USE 4-DIGIT YEAR
ID NUMBER _____ GROUP NUMBER _____

Please list the family members or significant others, if any, whom we may inform about your medical condition.

ONLY IN AN EMERGENCY:

Name _____ Phone () - _____

Name _____ Phone () - _____

REFERRED BY _____ PHYSICIAN NAME: _____

Has your doctor informed you of your diagnosis? Yes () No () Prognosis? Yes () No ()

Do you have durable power of attorney for healthcare providers? Yes () No ()

Reason for visit: _____

Date of illness (first symptom) _____ or Injury _____

Have you received a kidney transplant? Yes () No () If yes, date _____

Have you received maintenance dialysis treatments? Yes () No () If yes, date _____

Are you entitled to Black Lung Medical Benefits? Yes () No ()

Do you have a fee service card from the Department of Veteran's Affairs? Yes () No ()

Is this service for treatment of a work-related injury or illness: Yes () No ()

If yes, provide Name/Address of Worker's Compensation Agency _____

Is this service for the treatment of an illness or injury which resulted from an automobile or other accident? Yes () No ()

If yes, provide Name/Address/Policy Number of Automobile Insurer: _____

Are the services to be paid by a program such as a Government Research Grant? Yes () No ()

Are you currently receiving services anywhere else? Yes () No ()

If yes, WHERE? _____

Are you receiving services from Nevada Early Intervention Services? Yes () No ()

AGREEMENT / AUTHORIZATION FOR SERVICES

(1) It is necessary for you to comply with your treatment program prescribed by your physician and provided by your therapist. In order for you to achieve the desired results it is necessary to receive treatment consistently. Cancellations should be made at least twenty-four (24) hours in advance of appointment. Our goal is to provide you with the highest quality of treatment. We encourage you to ask questions if the plan is not clear. We also encourage family members to become involved and welcome any comments and suggestions. (2) **Payment is expected at the time of service**, unless prior arrangements have been made. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. Patients who carry medical insurance should remember that all professional services are rendered and charged to the patient, not the insurance company. **The obligation for the full payment of this account remains your own and if the insurance company fails to make payment within forty-five (45) days you will be expected to pay the total balance of this account.**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process claims.

Signed _____ Date _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to The Continuum for services rendered.

Signed _____ Date _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

PATIENT: _____ DATE OF BIRTH _____

This is to authorize that the information regarding the above individual be forwarded by mail, fax or phone.

FROM:

(Name and address of facility from
which information is being requested)

BE SENT OR GIVEN TO:

(Name and address of facility, attorney,
insurance co., or person information is
being released to)

REASON FOR REQUEST:

(Continuing care, investigation, personal)

INFORMATION REQUESTED:

(Specifics as to part of record requested; or,
if complete chart, dates of treatment)

I acknowledge that information to be released may include alcohol and/or drug abuse or psychiatric information that is protected by Federal regulations; my signature authorizes release of such information.

Signature of Witness

Signature of Patient / Parent / Patient Representative

Date

Time

This content is subject to revocation by the patient at any time, in writing, except to the extent that action has been taken in reliance hereon. This consent will terminate 1 year from date listed above.

**The Continuum
Consent for Photography, Audio-Taping, and/or
Video-Taping and Release**

I authorize The Continuum to photograph, video and/or audio tape _____,
which **may** be used for clinical purposes.

I do not authorize The Continuum to photograph, video and/or audio tape _____,
for clinical purposes.

I authorize The Continuum to photograph, video and/or audio tape _____,
which **may** be used for marketing purposes.

I do not authorize The Continuum to photograph, video and/or audio tape _____,
for marketing purposes.

Client Name

Signature of Client / Parent / Guardian

Date

THE CONTINUUM

Pediatric Case History

Please fill out this form as completely as possible. This history form provides necessary background information so your therapist can prepare the most appropriate evaluation.

Today's Date: _____

Child's Name: _____ Age: _____ Grade _____ Sex: M F

Date of Birth: _____ Relationship to child: _____

Teacher: _____

FAMILY HISTORY

Is there a history of developmental delays in any area (e.g. speech, motor skills)?

Father/Father's Family – (please indicate the family member and the diagnosis):

Mother/Mother's Family – (please indicate the family member and the diagnosis):

Siblings – (please indicate the family member and the diagnosis):

Where does the child currently live? Who lives in the home? Please list ages of other children in the home.

Is there a social worker or case manager involved in this child's care? Yes _____ No _____
(If yes, please list names and contact information):

PREGNANCY AND BIRTH HISTORY

Did the Mother receive prenatal care? Yes _____ No _____ (If no, please explain):

Were there any pregnancy complications (e.g. Pre-Eclampsia, Gestational Diabetes, Bed Rest)?

Yes _____ No _____ (If yes, please explain):

Was the child delivered full-term? Yes _____ No _____ (If no, at what week) _____

Was the birth vaginal or C-Section _____

Was the child in intensive care for any reason? Yes _____ No _____ (If yes, please explain):

Were there any complications at birth (e.g. lack of oxygen, low APGAR scores)? Yes ____ No ____
 (If yes, please explain): _____

DEVELOPMENTAL HISTORY

Please indicate at what age your child achieved the following skills:

Activities of Daily Living	Yes	No	At what age?	Comments
Self-feeding	<input type="checkbox"/>	<input type="checkbox"/>		
Toilet-trained	<input type="checkbox"/>	<input type="checkbox"/>		
Dressed independently	<input type="checkbox"/>	<input type="checkbox"/>		
Brushed teeth independently	<input type="checkbox"/>	<input type="checkbox"/>		

Motor Skills	Yes	No	At what age?	Comments
Rolled over	<input type="checkbox"/>	<input type="checkbox"/>		
Sat independently	<input type="checkbox"/>	<input type="checkbox"/>		
Crawled	<input type="checkbox"/>	<input type="checkbox"/>		
Took first steps	<input type="checkbox"/>	<input type="checkbox"/>		
Walked independently	<input type="checkbox"/>	<input type="checkbox"/>		

Speech and Language Skills	Yes	No	At what age?	Comments
Babbled	<input type="checkbox"/>	<input type="checkbox"/>		
Spoke first word	<input type="checkbox"/>	<input type="checkbox"/>		
Combined 2 or more words	<input type="checkbox"/>	<input type="checkbox"/>		
Brushed Teeth Independently	<input type="checkbox"/>	<input type="checkbox"/>		

Feeding and Swallowing	From age	To age	Comments
Used a bottle			
Used a sippy cup			
Used a regular cup			
Ate solid foods			

Sensory Issues

	Yes	No	What is their reaction or response?
Does your child tolerate bath time?			
Does your child tolerate have his teeth brushed?			
Does your child tolerate "messy" hands during play or eating?			
Does your child tolerate having his hair cut?			
Does your child appear to take excessive risks?			
Does your child "bump" into things (e.g. walls) more than other children his age?			

MEDICAL HISTORY

Please list any serious illnesses/accidents/hospitalizations (past or present) _____

Are there any medical diagnosis? _____

Does the child have a history of ear infections? If yes, how were they treated (meds, tubes, etc.)?
 Has the child's hearing been evaluated? If so, what were the results? _____

Has your child's vision been evaluated? When and by whom? What were the results? _____

Any allergies to food, environmental items we should know about? Yes _____ No _____ (If yes, please list the items): _____

Additional History

Does the child have any unusual fears? Yes _____ No _____

Does your child interact appropriately with children the same age? Yes _____ No _____

Does the child have any behavioral issues that are a problem? Yes _____ No _____

Describe items your child finds reinforcing (food, stickers, TV characters, etc.) _____

Why are you seeking therapy at this time? What are your goals? _____

Thank you for taking the time to complete this form. This information will be very helpful to your therapist in helping to create a therapy program specific to your child's needs.

FAMILY HISTORY

Family history forms are required only if the client is receiving all three therapies; Speech, Occupational and Physical Therapy. We ask that a family member or close friend complete this form. Some of our clients are unable to supply this information which is extremely helpful in providing the most effective treatment. In addition, it will help us provide activities that are of interest to the client. Some of the questions may not pertain to your family member, if this is the case please write "DNA" (does not apply) in the space.

General Information:

Married _____ Date _____ Single _____ Divorced _____ Widowed _____
Date _____
Name of Spouse _____
Parent's names _____
Are parents living? _____ If so, where _____

School and Work History

Schools attended/Grade School, High School _____
College _____
Degrees _____
Favorite subjects in school _____
Work History _____ Date of Retirement _____
Attitude toward work (like/dislike) _____
Does client speak more than one language? _____
Does client do any writing? _____ longhand _____ printing _____ computer _____
Does client read? _____ books _____ kinds of books _____ magazines _____
newspaper _____

Personal Interests

Hobbies/interests _____
Recreation: outdoors _____ indoors _____
Play any musical instruments: _____
Other skills/talents (art, typing, sports, singing, etc.) _____
Club/Organizations/Church (membership) _____

Family Goals and Information

Would family be available to attend therapy? _____
Family's impression of major strengths _____
What are the goals of the client? _____
If applicable, what type of positive reinforcement may motivate client? _____
Any topics of discussion to be avoided? _____
Reaction of friends and relatives since onset _____

Client's sons, daughters, and grandchildren

Name	Nickname	Relationship	Age	City/State

Other close relatives

Name	Nickname	Relationship	Age	City/State

Close friends/associates (neighbors, church, co-workers, etc.)

Name	Nickname	Relationship	Age	City/State

Medical Information

Primary Diagnosis_____

Approximate date of onset_____

Describe any major illness or accident in addition to primary diagnosis_____

Since this onset_____

Personality characteristics prior to onset (outgoing, shy, social etc.)_____

Personality characteristics since onset_____

Is client continent? Yes/No_____ Daytime_____ Nighttime_____

FUNCTIONAL ASSESSMENT

*Please check appropriate box

FUNCTIONAL MOBILITY	FUNCTIONAL MOBILITY	FUNCTIONAL MOBILITY	FUNCTIONAL MOBILITY
TRANSFERS	WALKING	WHEELCHAIR SKILLS	HOME ENVIRONMENT
INDEPENDENT	INDEPENDENT	INDEPENDENT	HOME IS ADAPTED FOR NEEDS
ASSISTED	ASSISTIVE DEVICE	ASSISTED	HOME REQUIRES ADAPTIVE EQUIPMENT
DEPENDENT	STAND BY ASSIST	DEPENDENT	
DRESSING SKILLS	DRESSING SKILLS	PERSONAL GROOMING	PERSONAL GROOMING
CLOTHING	SHOES & SOCKS	DENTAL CARE (TEETH/DENTURES)	HAIR/SHAVING/MAKE-UP/ BATHING
INDEPENDENT	INDEPENDENT	INDEPENDENT	INDEPENDENT
ASSISTED	ASSISTED	ASSISTED	ASSISTED
DEPENDENT	DEPENDENT	DEPENDENT	DEPENDENT
HOUSEHOLD CHORES	HOUSEHOLD CHORES	HOUSEHOLD CHORES	HOUSEHOLD CHORES
LAUNDRY	DISHES	CLEANING	COOKING
INDEPENDENT	INDEPENDENT	INDEPENDENT	INDEPENDENT
ASSISTED	ASSISTED	ASSISTED	ASSISTED
DEPENDENT	DEPENDENT	DEPENDENT	DEPENDENT

ADDITIONAL INFORMATION
