OPPORTUNITY PROJECT, INC.
A Clubhouse Program Empowering People with Brain Injury

Opportunity Project Inc
Initial Screening & Referral Form for Potential Members

Date:

Packet Sent Date:

Tour/ Interview Date:

General Information

- Name of Person Calling:
- Relationship to Applicant:
- Phone Number (if different than applicant)
- Referred By:

Potential Member Information

a. Applicant's Name:

b. Applicant's Address:

c. Applicant's Phone Number:

d. Applicant's Current Age:

e. Nature and Date of Injury:

f. Current Situation:

g. Living Arrangements:

h. What is your primary source of income?

i. Bathroom Use:

j.

Fully Independent

Partially Independent (Please Explain)

Dependent? Aid?

k. Does the applicant have any behavioral and/or personality changes since acquiring the brain injury? If so, explain?

Medical Information

a. Name of Doctor or Rehabilitation Professional

b. Specialty:

c. Address:

d. Phone Number

e. Using Medications?

f. List of Medications:

g. Has a medical /neuropsychological evaluation been performed? Can the applicant provide a copy?

Transportation Needs

a. Is Transportation required?

b. How will the person travel to the program?

Access Link	Access Link number?
Medical Transportation	Company used?
Family Member	Who?
Drives Self	

Criminal Background

1. Has the applicant ever been arrested?
   If so, explain:

2. Is there a history of substance abuse?
   If so, explain:

Funding Source

1. **DVR**
   Counselor Name:

   Counselor Phone Number:

2. **TBI Medicaid Wavier**
   Case Manager Name:

   Case Manager Phone Number:

3. **DDD**
   Case Manager Name:

   Case Manager Phone Number:

4. **Private Insurance:**
   Case Manager Name:

   Case Manager Phone Number:

5. **TBI Fund**
   Case Manager Name:

   Case Manager Phone Number:

6. **Private Pay**
   Source of Income:

Additional Information: