Integrated Living Opportunities (ILO)
Individual History Information

Date: _____

Name: _____
Address: _____
Address: _____
Date of Birth: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
E-mail: _____

Parents/Caregiver

Name: _____
Address: _____
_____
Relationship: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
E-mail: _____

Name: _____
Address: _____
_____
Relationship: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
E-mail: _____

Other Involved Family Members

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Legal Guardian (if applicable)

Name: _____

Home Phone: _____
Work Phone: _____

Medical Information

Disability Diagnosis:

How does the individual's disability impact day-to-day living?

Describe any activity restrictions:

Describe any dietary needs or restrictions:

Seizure Disorders

Does this individual have seizures? ☐ Yes ☐ No If yes, please describe:
What happens?

How often do they occur? _____
How long do they last? _____
Are there any warning signs (cries, acts strangely, etc.)?

_____
Is there post-seizure sleepiness, confusion, unsteady walk or other effects? Please describe:

_____
List any seizure medications and when they are taken:

_____

Please check and describe any chronic medical conditions:

☐ Heart Disease _____
☐ High Blood Pressure _____
☐ Diabetes _____
☐ Cancer _____
☐ Gastrointestinal Disorders _____
☐ Chronic Skin Disorders _____
☐ Neurological Disorders _____
☐ Glaucoma _____
☐ Other _____

Has the individual ever participated in therapy with a psychologist, psychiatrist, or social worker? ☐ Yes ☐ No
If yes, please fill in the information below:

When	Name of therapist	Reason for Therapy
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the individual have a history of depression, anxiety, or suicide attempts? If yes, please indicate the duration and any treatment (therapy, medication):

Any other psychological/emotional issues?

Please describe any other medical information we need to know (assistance needed, medications, etc.):

Historical Information

Please describe current and previous living situations:

Please describe current and previous work situations:

Please describe current and previous school situations:

Residential Setting and Housemates

Please answer all of the following as they pertain to your ideal residential setting:

Geographic area(s): _____

When do you want it to start? _____ When does he/she want it to start? _____

Estimated hours of support needed daily: _____ Estimated hours of support needed weekly: _____

Can the individual remain in the house alone? _____ How long can he/she stay alone? _____

Individual prefers a: ☐ single apartment ☐ shared apartment (own bedroom)

If shared, ideal number of housemates: _____

Please describe the characteristics you hope to see in housemates/residential community members:

Please describe other important characteristics of the ideal residential setting:

Please rank each of the following according to its importance to your ideal residential setting. If there are items on which you won't compromise, please indicate so.

1 - Very important to me 2 - Nice but not essential 3 - Irrelevant to me

In my house or residential community setting . . .

____ My housemates/community members will be of similar age, within 5 - 10 years (indicate age range _____)
____ My housemates/community members will be of a similar religion (If 1 or 2, indicate religion _____)
____ My housemates/community members will all be the same gender
____ My housemates/community members will have similar interests and hobbies
____ My housemates/community members will be people I already know and am comfortable with
____ I will have previous knowledge or a relationship with the other families

Financial Information

Please indicate which of the following you are receiving and tell us the amount from each source:

____	SSI	Amount	_____	____	State Waiver DDS/DDA	Amount	_____
____	SSDI	Amount	_____	____	Snap Benefits/Link Card	Amount	_____
____	Medicaid			____	Self-Directed Maryland	Amount	_____
____	Medicare						
____	Other	Amount	_____	Please specify source:			_____
____	Other	Amount	_____	Please specify source:			_____

Current representative payee: _____

SSI Contact: _____
Phone: _____
Address: _____
_____
_____

PAS Agent: _____
Phone: _____
Address: _____
_____
_____

	Yes	No
Do you have an Individual Section 8 Housing Voucher?	☐	☐
If not, do you plan to apply for Section 8 housing?	☐	☐
Do you have a Project Public Housing Voucher?	☐	☐
If not, do you plan to apply for a Project Public Housing Voucher?	☐	☐
Do you know what public benefits are available to you?	☐	☐
Do you need help accessing your public benefits?	☐	☐

Individual	Parent/Caregiver
What transitional changes do you anticipate will be the most significant for you?	What transitional changes do you anticipate will be the most significant for the individual?
What transitional changes do you anticipate will be the most significant for your family?	What transitional changes do you anticipate will be the most significant for you?
When you think about moving into a more independent living option, what is your biggest fear?	When you think about the individual moving into a more independent living option, what is your biggest fear?

Transitional Questions

IMPORTANT NOTE: Please be sure to provide copies of past documentation from schools, psychologists, vocational and educational consultants and any other agencies or professionals that can help inform ILO staff regarding support needs for the individual.