

UCP of East Central Florida/WORC
www.ucpecf.org

Date:

To Whom It May Concern:

UCP of East Central Florida/WORC has started a program called

Attached you will find a referral/application to the *****.
The referral form lists the criteria for the program, which is also reiterated below. If you are currently assisting or will be assisting an individual with a traumatic brain injury whom you feel may need some adjustment before entering an employment position, please do not hesitate to refer him/her to our program.

Criteria for *** program:**

- Ages 18 and older
- Diagnosed with a traumatic brain injury
- At least 2 years post injury
- Desire to obtain employment

This grant-funded program has been sponsored by Brain Injury Association of Florida and will be available until June 30th, 2007. If you have any questions about this program, please contact *****. Thank you for your time and we look forward to working with you.

(name of counselor)**

**UCP of East Central Florida/WORC
Application for TBI Program**

Minimum Criteria to Participate in Program:

1. Age 18 or older
2. Diagnosed with a traumatic brain injury
3. At least 2 years post injury
4. Interested in obtaining long-term employment

Name: _____ Date of request: _____

Address: _____

City, State, Zip: _____ County: _____

Date of Birth: _____ Sex: _____

Telephone: _____

Have you been diagnosed with a traumatic brain injury? Yes No

How many years has it been since your last injury? _____

Do you have a desire to obtain employment? Yes No

Referral Source:

- ___ Self-Referral
- ___ Vocational Rehabilitation Services
- ___ Brain Injury of Florida
- ___ Shands Rehab
- ___ Other: _____

Signature of Applicant

Date of Application

**Please mail or fax this form to: Attn: Kelly Johannesson
UCP/WORC 1100 Jimmy Ann Drive DB, FL 32117 Fax (386) 274-6532**

This program is sponsored by Brain Injury Association of Florida
www.biaf.org

(On UCP/WORC Letterhead)

UCP of East Central Florida/WORC

Date:

Referral Name

Address

City, State Zip

Re: Appointment for the Vocational Guidance and Disability Adjustment Counseling

Dear **Referral Name**,

We have received a referral/application from _____ to enroll in the traumatic brain injury transition to work program through UCP of East Central Florida/WORC. In order to begin services, an intake appointment has been scheduled for Day, Date, at Time at our office located at 1100 Jimmy Ann Drive, Daytona Beach, FL 32117.

Please contact me at 386-274-6474 x 21 to confirm your attendance at this meeting or to re-schedule for a later date. In addition, if you require any sort of accommodation to participate in this meeting, please notify me as well.

If you have a recent neuropsychological report, current list of medication, and/or medical report, please bring a copy with you.

In addition, we encourage natural supports to be in attendance during the intake interview. Please feel free to bring family members or other supports to the appointment. **The Vocational Guidance and Disability Adjustment Counseling team looks forward to meeting with you and assisting you in regaining employment through adjustment counseling, independent living skills, and pre-employment workshops.**

Sincerely,

Kelly Johanessen
Vice President of Operations

What You Should Know About Counseling...

Counseling is a process of self-examination and looking at problems or issues in your life. These might include matters such as depression, addiction, behaviors you would like to change, relationship problems, eating disorders, emotional problems, physical or mental illness, or any other issue that is causing you distress. When you come to a session, we will address your problems and concerns.

You are the most important participant in the counseling relationship. We will work together but you are the one who ultimately makes your own decisions regarding your treatment and your life. The overall goal of the counseling process is to help you feel better over time as you progress through your sessions-feeling “cured” probably will not happen right away.

What are the risks and benefits of counseling?

Most people who enter counseling come out of it feeling better, but during the counseling process, issues and feelings that could cause distress-at least temporarily. These include feelings of depression, anxiety, pain, anger, frustration, and disruption in your life. For most people, self-examination and change are difficult, but for most people, it is well worth it because of the improvement they experience.

Will my information be shared with other people?

What we will talk about in our sessions will be shared with the other team members of the **transition work program**. The other team members are *****. Information is shared with my team members to gain insight in order to assist you in your overall goal of adjustment. If permitted by you, information may be shared with family members. Also, if something you say leads me to believe you might harm yourself or others, or if you or someone about the abuse of a child, abuse of the elderly, or abuse of a person with disabilities, the law says that I must report it.

How long do sessions last and how many will I have?

Each session lasts about 45 minutes. The number of sessions varies. It really depends upon your needs and the issues you are dealing with, but you can expect your counseling will end when you have achieved the maximum benefits from it or have obtained what you were seeking when you started.

How should I schedule or cancel appointments?

Talk with me while you are at ***** or call me at *****. Please let me know as soon as possible if you need to cancel an appointment. If I am not available, please leave a message with *****.

If I am unhappy with my counselor or unsatisfied with services, what should I do?

I hope you will let me know if you feel there is a problem with the counseling you are receiving so that we can discuss it and try to find a solution. If you have a complaint that you would prefer to bring to someone else besides me, please speak with *****

What if I wish to stop coming to counseling?

If you choose to stop counseling services, please talk with me about it first so that we can make a plan together. That may include a referral to another professional or to community services/resources.

What if I want to continue counseling after our sessions have ended?

When your sessions have ended and you wish to continue counseling, *****will refer you to other services available in the community. Please add in local resource information.*****

What if I have questions?

If you have questions or concerns about information in this document, matters relating to counseling, or anything that is covered in your sessions, always feel free to ask me. Your understanding will help you make effective choices for yourself and help you fully participate in your treatment.

About the counselor...

I use a variety of approaches and techniques when working with clients, depending upon the issues each person wants to work on. I see the therapeutic relationship as a partnership in which your role is of primary importance. Ultimately, you are the one responsible for making decisions for yourself. I am here to assist you in the process.

Name
Credentials

Contract for Participation in Adjustment Counseling

Consumer

I, *****, understand and agree to the following guidelines for my participation in counseling while a consumer at UCP of East Central Florida/WORC.

1. I will attend all sessions, arriving promptly. In the event of an unavoidable scheduling conflict, I will call my counselor at least 24 hours in advance to cancel my appointment.
2. I understand that I will help to set my goals, can discuss my progress at any time, and will periodically prepare a summary of my progress.
3. I will bring a note pad and pen/pencil to each session and will take notes as necessary.
4. I understand that my sessions may be videotaped or audiotaped for use in my treatment (to assist in self-awareness, memory, etc.) and that tapes will not be shown to anyone other than the counselor and the counselor's team members without my permission. I also understand that any information discussed during the counseling can be shared with the counselor's team members.
5. I will complete all assigned home practice and bring any written home practice assignments to the next sessions. If I have not done assigned home practice, I understand that I may be asked to complete it at the beginning of my scheduled counseling sessions.
6. I would like to add the following items to this contract:

***** (consumer name) *****

***** (date) *****

Contract for Participation in Adjustment Counseling

Counselor

I, *****, agree to the following guidelines:

1. I will attend all sessions, arriving promptly and ending promptly. In the event of an unavoidable conflict, I will call the consumer at 24 hours in advance.
2. I agree to set goals with the patient and review progress at any time.
3. I will review all out-of-sessions assignments with the consumer.
4. I will be available during work hours for assistance should the consumer have questions on out-of-sessions assigned tasks.
5. If the patient does not complete assignments, I agree to thoroughly review the reasons for this and endeavor to assist the consumer in completing assignments.
6. I agree to behave in a professional manner and maintain compliance with ethical codes.

***** (counselor name) *****

***** (date) *****

**UCP of East Central Florida/WORC
Intake Form**

Consumer: _____

Interviewer: _____ Date: _____

HOUSING

What is your current housing situation? (please check)

<input type="checkbox"/>	Institution/Nursing Home	<input type="checkbox"/>	Dependent with Family/Friends
<input type="checkbox"/>	Assisted Living	<input type="checkbox"/>	Own Home
<input type="checkbox"/>	Public Housing/Section 8	<input type="checkbox"/>	Rent

Are you happy and safe in your home? Yes ___ No ___

If no, would you like assistance in securing stable housing? Yes ___ No ___

Type of Housing Assistance Requested? _____

Is your residence accessible? Yes ___ No ___ If no, what type of modifications to your residence would increase your independence? _____

Is your residence within city limits? Yes ___ No ___

Notes/Additional Information: _____

FAMILY/SUPPORTS

<input type="checkbox"/>	Married	<input type="checkbox"/>	Single
<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Widowed
<input type="checkbox"/>	Child(ren)	<input type="checkbox"/>	Separated

Who are the people you rely most on in your life? _____

Notes/Additional Information: _____

TRANSPORTATION

Do you have a valid Florida Driver’s License? Yes ___ No ___

Has anyone ever stated that you should not be driving? (i.e. Physician, Therapist, Police)

Yes ___ No ___ If yes, when? _____

Are you legally permitted to drive a vehicle in Florida? Yes ___ No ___

Are you currently driving? Yes ___ No ___

Do you have reliable transportation? If yes, what type?

<input type="checkbox"/>	Drive Vehicle	<input type="checkbox"/>	Bicycle
<input type="checkbox"/>	Public Transportation	<input type="checkbox"/>	Family Members
<input type="checkbox"/>	ADA Paratransit Services	<input type="checkbox"/>	Transportation Disadvantage

Would you benefit from any of the following services? (if applicable to Geographic Area)

<input type="checkbox"/>	Public Transportation	<input type="checkbox"/>	Travel Training
<input type="checkbox"/>	ADA Paratransit Services	<input type="checkbox"/>	Transportation Disadvantage
<input type="checkbox"/>	Driving Evaluation Referral	<input type="checkbox"/>	Tutoring for Driver’s License and/or Learner’s Permit

Notes/Additional Information: _____

BENEFITS

Do you currently receive/have the following benefits?

<input type="checkbox"/>	SSI: \$ _____ /month	<input type="checkbox"/>	Medicaid #
<input type="checkbox"/>	SSDI: \$ _____ /month	<input type="checkbox"/>	Medicare #
<input type="checkbox"/>	Workers Compensation	<input type="checkbox"/>	Private Health Insurance
<input type="checkbox"/>	Legal Settlement	<input type="checkbox"/>	Trust Fund
<input type="checkbox"/>	Life Care Plan	<input type="checkbox"/>	

Please check if you would like assistance in obtaining the following benefits.

<input type="checkbox"/>	Social Security Benefits	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	Medicare	<input type="checkbox"/>	BPAO

Source(s) of Income/Support: _____

Notes/Additional Information: _____

EDUCATION/WORK EXPERIENCE

Name/Location of High School: _____

Dates of Attendance: _____

<input type="checkbox"/>	High School Diploma	<input type="checkbox"/>	Did not Graduate
<input type="checkbox"/>	Special Diploma	<input type="checkbox"/>	GED
<input type="checkbox"/>	Some College	<input type="checkbox"/>	Graduated College
<input type="checkbox"/>	Post Graduate	<input type="checkbox"/>	

Name/Location of Post Secondary Education/Post Graduate: _____

Dates of Attendance: _____

Military: _____ Dates of Service: _____

Are you currently employed? Yes ___ No ___

If Yes, please provide Employer Information below.

Employer: _____ Start Date: _____

Job Title and Duties: _____

Work Experience (Start with most recent position)

Employer: _____ Start Date: _____

Job Title and Duties: _____

What was your favorite part of the job? _____

Employer: _____ Start Date: _____

Job Title and Duties: _____

What was your favorite part of the job? _____

Employer: _____ Start Date: _____

Job Title and Duties: _____

What was your favorite part of the job? _____

Volunteer Experience: _____

Are you aware of how work may impact your benefits? Yes ___ No ___

Have you met with a benefits Planner regarding the impact of employment on your benefits? Yes ___ No ___ If No, would you like to be referred? Yes ___ No ___

PERSONAL HABITS

Is there any legal history that may show up on a criminal background check when applying for the job? _____

Do you smoke? Yes ___ No ___ If Yes, frequency/amount: _____

Do you drink? Yes ___ No ___ If Yes, frequency/amount: _____

Do you use illegal drugs? Yes ___ No ___ If Yes, type/frequency/amount: _____

Comments:

For Office Use Only:

Participant ID#: _____

Referral Date: mm/dd/yy: _____

Referral Source: BSCIP (1) BIAF (2) VR (3) SELF (4) _____

Time Post Injury: mm/yy: _____

Level of Education:

Some high school (1) Diploma (2) GED (3) Some College (4) College Degree (5)

Age: _____

Ethnicity:

White (1) African American (2) Asian (3) American Indian/Alaskan Native (4)

Hawaii/Pacific Islander (5) Other (6) _____

Gender: Male (1) Female (2)

Living Situation: Alone (1) Spouse (2) Family/Friend (3) Other (4) _____

Rancho Level: If reported: _____

**UCP of East Central Florida/WORC
TBI Adjustment Counseling Intake Form**

Consumer: _____

Interviewer: _____ Date: _____

I. Injury-Related Information:

1. When did your brain injury occur? _____

2. How did your brain injury occur?

___ Fall

___ Assault

___ Motor vehicle accident

___ Other: _____

Please describe in further detail:

Have you sustained an additional brain injury since your initial injury?

Yes ___ No ___

If yes, please describe in further detail:

3. Have you received any type of inpatient medical and/or rehabilitation services? Yes ___ No ___

If yes, please provide the name of the Rehabilitation Center(s), duration of services, type of services and other pertinent information:

Have you received any type of outpatient medical and/or rehabilitation services? Yes ___ No ___

If yes, please provide the name of the Rehabilitation Center(s), duration of services, type of services and other pertinent information:

4. Are you currently receiving rehabilitation services? Yes ___ No ___

If yes, please list name of service provider and type of rehabilitation services: _____

5. Have you received services from the Florida Brain and Spinal Cord Injury Program? Yes ___ No ___

If yes, what type of services? _____

Name of Case Manager: _____

Have you received services from the Brain Injury Association of Florida? Yes ___ No ___

If yes, what type of services? _____

Name of Case Manager: _____

II. Adjustment:

1. Have you received any type of psychotherapeutic services after sustaining your head injury? Yes ___ No ___
If yes, please provide the name of the therapeutic provider, type of treatment and dates you received services: _____

Name of provider: _____

2. How many hours during the 24-hour day do you sleep? _____
3. How many hours at one time do you sleep? _____
4. Do you feel you have trouble sleeping? Yes ___ No ___
If yes, do you have trouble with the following?

<input type="checkbox"/>	Falling Asleep	<input type="checkbox"/>	Early Awakening
<input type="checkbox"/>	Interrupted Sleep	<input type="checkbox"/>	Awakening Not Feeling Refreshed

5. Do you take medication to fall asleep? Yes ___ No ___
If yes, type of medication? _____
How long have you taken this medication? _____

6. Please list other medications you are currently taking:
- Medication #1: _____
Frequency: _____ Dosage: _____ Type: _____
- Medication #2: _____
Frequency: _____ Dosage: _____ Type: _____
- Medication #3: _____
Frequency: _____ Dosage: _____ Type: _____
- Medication #4: _____
Frequency: _____ Dosage: _____ Type: _____

7. Since your injury, have you experienced difficulty with your diet/appetite? Yes ___ No ___
If yes, how would you describe your appetite? _____

Have you experienced any weight gain? Yes ___ No ___
Have you experienced any weight loss? Yes ___ No ___

8. Have you ever been Baker Acted or admitted to a Crisis Stabilization Unit? Yes ___ No ___
If yes, please list date(s) and location(s): _____

9. Please share any additional information that you feel we have not covered that you feel may influence your performance in this program: _____

Have you experienced difficulties with any of the following?

	Pre-Injury	Post-Injury
Self-Care		
Showering, grooming, dressing, using the bathroom, etc?		
Bowel/Bladder functioning?		
Maintains hygienic practices?		
Mobility		
Ambulate independently?		
Maintain balance?		
Maintaining Personal Relationships		
Maintains appropriate distance when talking to others?		
Initiates conversations?		
Ends conversations appropriately?		
Able to keep conversations brief?		
Able to be flexible if an unexpected issues occurs? (i.e. friend cancels lunch date)		
Avoids asking/making embarrassing or hurtful statements to others?		
Refrains from inappropriate touching or sexual remarks?		
Ability to maintain a personal relationship (dating, marriage, etc.)?		
Issues with sexual performance?		
Apologizes for mistakes or errors in judgment?		
Coping Skills/Adjustment		
Controls feelings of anger when individual is denied their “own way”?		
Able to control self from becoming physically/verbally aggressive?		
Controls anxiety of being alone?		
Feels comfortable in public?		
Feels adjusted to their disability?		
Smokes cigarettes – amount/how often		
Drinks alcohol – amount/how often		
Scale 1 (Excellent) – 5 (Very Poor) Feels adjusted to Disability	N/A	N/A
Experiences on-going feelings of sadness or depression about life situation?		
Able to manage time efficiently and effectively?		
Feels irritable or impatient when something happens and results in a change of daily routine?		

	Pre-Injury	Post-Injury
Communication/Cognition		
Understands the meaning of yes/no?		
Able to concentrate on one activity at a time?		
Able to do multiple activities at one time? (multitasking)		
Knows correct date, name birth date, and/or current address?		
Remembers childhood and attending school?		
Uses complete sentences?		
Able to do basic reading?		
Able to solve basic math problems?		
Able to write name/address, etc.?		
Able to use and answer phone appropriately?		
Able to make own appointments?		
Able to keep appointments without assistance?		
Able to keep a daily schedule/log of activities?		
Able to follow a daily schedule?		
Able to remain safely unsupervised for at least one hour?		
Able to maintain attention/focus when being spoken to or completing a task?		
Begins activities by self?		
Able to concentrate on activities until completion?		
Maintains eye contact when speaking to others or being spoken to?		
Avoids interrupting others?		
Expresses feeling appropriately?		
Able to follow a set of rules?		
Develops and applies situational problem solving skills?		
Develops and applies situational decision making skills?		
Other Activities		
Participation in hobbies and/or activities	N/A	N/A
Obtaining/Maintaining Employment		
Attending/Completing Schooling		

Additional information:

This questionnaire has been adapted from FL BSCIP materials.

Worksheet List

Journal of Daily Experiences

Support Network

Time Management Inventory

Wellness Inventory

Memory Strategies

Memory Inventory

Decision Making

Problem Solving

Journal of Daily Experiences

Feelings and/or Behaviors		Action Taken	Good Result	Bad result
Irritability				
Aggression - verbal or physical				
Agitation – unable to settle down				
Anger				
Anxiety				
Depression				
Problems Concentrating				
Difficulty falling asleep or sleeping too much				
Trouble making decisions				
Problems communicating				
Not understanding or being understood				
Difficulty completing daily routine				
Diminished initiation (starting things)				
Diminished execution (doing things)				
Easily distracted				
Forgetfulness				

Support Network

1. Who are you able to talk to about things that are very personal?

Name(s): _____

Phone Numbers(s): _____

2. Who are some individuals that used their time and energy you help you take care of something that you needed to do? For example, personal helpers that help drive you someplace, help with some work around the house, go to the store for you, etc.

Name(s): _____

Phone Numbers(s): _____

3. Who are some people that you enjoy getting together with to have fun and relax?

Name(s): _____

Phone Numbers(s): _____

4. Identify three instances in which your needs for social support have gone unmet during the past year.

Name(s): _____

Phone Numbers(s): _____

5. Identify three instances in which your needs for social support have been well met during the past year.

Name(s): _____

Phone Numbers(s): _____

Time Management Inventory

Date:

Activity	Begin Time	End Time	Total Hours
Sleeping			
Resting			
Personal Grooming			
Planning your day			
Writing in your journal			
Meal planning/preparation			
Food shopping			
Care for pets			
Housecleaning			
Laundry			
Yard work			
Running errands			
Talking on the phone			
School work			
Sitting at the computer			

Watching TV	
Exercising	
Enjoying hobbies	
Feeling Tired	
Checking and rechecking	
Thoughts of doing harm to yourself or others	
Worrying about money	
Thoughts about the future	
Feeling lonely	
Wasting time	
Drinking or doing drugs	
Other-describe	
Other-describe	
Other-describe	
Other-describe	

TOTAL NUMBER SHOULD EQUAL 24

Wellness Inventory

How oriented did you feel today?

Very Moderately Hardly None

How rested did you feel when you work up this morning?

Very Moderately Hardly None

How energetic did you feel today?

Very Moderately Hardly None

How happy did you feel today?

Very Moderately Hardly None

How often did you lose it today (anger)?

Very Moderately Hardly None

How stressful was your day?

Very Moderately Hardly None

How well did you get along with others today?

Very Moderately Hardly None

How much were you able to stay on task today?

Very Moderately Hardly None

Please answer these questions with as much detail as possible:

1. What was most stressful to you today?

2. What was the most restful to you today?

Memory Strategies

- Develop a routine and stick to it
- Create a place for everything and store everything in its place
- Utilize a tote bag or back pack of the day
- Use a to do list
- Use a planner to keep track of important dates/appointments
- Use highlighters
- Use repetition

Memory Inventory

Questions

Would you consider your memory problems as major, moderate, or minor? (Circle one)

Major

Moderate

Minor

How is your memory compared to the way it was...?
(Circle one)

Before your brain injury

Worse

Same

Better

After your brain injury

Worse

Same

Better

How often do the following present a problem for you?
(Circle the one that applies)

Names

Always

Sometimes

Never

Faces

Always

Sometimes

Never

Appointments

Always

Sometimes

Never

Where you put things

Always

Sometimes

Never

Performing household chores

Always

Sometimes

Never

Directions to places

Always

Sometimes

Never

Phone numbers

Always

Sometimes

Never

Personal dates

Always

Sometimes

Never

Forgetting what you wanted to buy at the store

Always

Sometimes

Never

Forgetting what you wanted from a room

Always

Sometimes

Never

Beginning to do something and forgetting what you were doing

Always

Sometimes

Never

Knowing whether you've already told someone something

Always

Sometimes

Never

As you are reading a book, how often do you have trouble remembering what you have read...?

The opening chapters, once you have finished the book	Always	Sometimes	Never
Three chapters before the one you are currently on	Always	Sometimes	Never
The chapter before the one you are currently on	Always	Sometimes	Never
The paragraph before that one you are currently on	Always	Sometimes	Never
The sentence before the one you are currently on	Always	Sometimes	Never
How well do you remember things that occurred in the past if the event was...?	Always	Sometimes	Never

How well do you remember things that occurred in the past if the event was...?

Ten minutes ago	Bad	Fair	Good
An hour ago	Bad	Fair	Good
Yesterday	Bad	Fair	Good
Last week	Bad	Fair	Good
Last month	Bad	Fair	Good
Before brain injury	Bad	Fair	Good
After brain injury	Bad	Fair	Good

How often do you use the following techniques to remind yourself about things...???

Keep an appointment book	Always	Sometimes	Never
Write yourself reminder notes	Always	Sometimes	Never
Make lists of things to do	Always	Sometimes	Never
Have people call you	Always	Sometimes	Never
Make grocery lists	Always	Sometimes	Never
Plan your daily schedule in advance	Always	Sometimes	Never
Keep things in a particular place	Always	Sometimes	Never
Alarm clock	Always	Sometimes	Never

Revised March 2007

Decision Making

- What is the question, issue, or problem?

- Do you have information you need to make a decision?

Yes No

If no, take the time to gather the information.

- Do you know what your options are?

Yes No

Identify and rank order your options below:

- Have you faced and made this same decision before?

Yes No

Take time to weigh and consider your options.

- Was your last decision sound?

Yes No

Review and evaluate what you did

- Make the decision!!!

Problem Solving

The following questions pertain to current problems:

I ignore the problem and pretend it was not happening

Never Rare Sometimes Often

I try to make myself better by eating, drinking, smoking, taking medications

Never Rare Sometimes Often

Let someone else handle the problem

Never Rare Sometimes Often

I blamed someone else for the problem

Never Rare Sometimes Often

I criticized or blamed myself

Never Rare Sometimes Often

I kept my feelings about the problem to myself

Never Rare Sometimes Often

I talked to someone about the problem

Never Rare Sometimes Often

I asked someone for advice about the problem

Never Rare Sometimes Often

I analyzed the problem and changed something so things would turn out all right

Never Rare Sometimes Often

I came up with a couple different solutions to the problem

Never Rare Sometimes Often

Total score:

Score of never=0, rare-1, sometimes=2, often=3.

A score of 30-51 indicates that your approach to problem solving might seriously hinder your efforts toward self-management. You will need to build essential skills before attempting self-management.

A score of 18-29 suggest that you regularly apply critical thinking skills to solving problems. Congratulations, the pages concerned with self-management and self-advocacy will enhance your existing skills.

A score of 0-17 calls into question the efficacy of your problem solving skills, review the skills that you regularly apply to problem solving and proceed to pages concerning self-management and self-advocacy to build more effective skills.