

**THRIVE PROGRAM**

##### Applicant Questionnaire

Name:

Why would you like to participate in the THRIVE Program? What strengths do you bring to the program? What knowledge and skills would you like to gain? (Feel free to add pages or write on the back of this form.):

##### PERSONAL SUPPORT INVENTORY

Please indicate the level of support you currently need in each area below. These are skills that the THRIVE Program is designed to address; therefore, we would not expect you to be completely independent on each competency prior to enrollment in the program.

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| --- | --- | --- | --- | --- | --- |
| **Independent Living Skills** | **Requires Complete Assistance** | **Needs Moderate Assistance** | **Needs****Some Assistance** | **Needs Minimal Assistance** | **Completely Independent** |
| Find your way around your neighborhood, or campus environment |  |  |  |  |  |
| Order and make purchases from a restaurant or store |  |  |  |  |  |
| Handle activities of daily living: hygiene, laundry, light cooking, cleaning |  |  |  |  |  |
| Use judgment skills in an emergency |  |  |  |  |  |
| Cope with stress and emotions |  |  |  |  |  |
| Adjust to new situations |  |  |  |  |  |

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| **Social Skills and Communication** | **Requires Complete Assistance** | **Needs Moderate Assistance** | **Needs****Some Assistance** | **Needs Minimal Assistance** | **Completely Independent** |
| Able to relate to peers |  |  |  |  |  |
| Ask for help or clarification |  |  |  |  |  |
| Communicate needs in an appropriate manner |  |  |  |  |  |
| Engage in appropriate social interaction |  |  |  |  |  |
| Uses telephone, email |  |  |  |  |  |
| Able to resist peer pressure |  |  |  |  |  |
| Recognize potentially dangerous situations |  |  |  |  |  |

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| **Academic and Career Skills** | **Requires Complete Assistance** | **Needs Moderate Assistance** | **Needs****Some Assistance** | **Needs Minimal Assistance** | **Completely Independent** |
| Attend school/work regularly |  |  |  |  |  |
| Get places on time, take appropriate breaks |  |  |  |  |  |
| Tell others your name, address, phone number, emergency information |  |  |  |  |  |
| Dress appropriately for the weather and situation |  |  |  |  |  |
| Meet hygiene expectations (take bath or shower, wash and style hair, use deodorant) |  |  |  |  |  |
| Motivated to learn and stick with new tasks |  |  |  |  |  |
| Complete assigned tasks |  |  |  |  |  |
| Accept corrective feedback |  |  |  |  |  |
| Check and self-correct work for completion and accuracy |  |  |  |  |  |
| Able to follow verbal directions |  |  |  |  |  |
| Able to follow written directions |  |  |  |  |  |
| Follow rules and safety procedures |  |  |  |  |  |
| Cooperate with team members |  |  |  |  |  |
| Get along with peers |  |  |  |  |  |
| Keep a daily schedule  |  |  |  |  |  |
| Able to tell time |  |  |  |  |  |
| Able to structure your own time |  |  |  |  |  |
| Math skills  |  |  |  |  |  |
| Reading skills |  |  |  |  |  |
| Writing skills  |  |  |  |  |  |
| Computer skills |  |  |  |  |  |

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| **Health and Medical Skills** | **Requires Complete Assistance** | **Needs Moderate Assistance** | **Needs****Some Assistance** | **Needs Minimal Assistance** | **Completely Independent** |
| Keep a calendar of doctor and dentist appointments and contact information |  |  |  |  |  |
| Know when and whom to call when sick or hurt |  |  |  |  |  |
| Know the difference between an emergency and minor illness  |  |  |  |  |  |
| Know where to go and how to get prescriptions filled |  |  |  |  |  |
| Understand “co-pay” for doctor, pharmacy |  |  |  |  |  |
| Know to ask the doctor or pharmacist questions |  |  |  |  |  |
| Know your own medication: name, purpose, side effects, restrictions |  |  |  |  |  |
| Recognize your own medication and when to take it |  |  |  |  |  |
| Know how often medications are to be taken  |  |  |  |  |  |
| Open “child resistant” caps or ask for bottles that can be opened  |  |  |  |  |  |
| Fill daily/weekly pillbox accurately |  |  |  |  |  |
| Know how to purchase and properly use over-the-counter medication |  |  |  |  |  |
| Know who to call with questions or to get help with medical concerns |  |  |  |  |  |

Is there anything else you would like us to know about you?

*THANK YOU!*