DAILY LIFE INVENTORY

Applicant Name: ____

A. BATHING, DRESSING AND GROOMING

Directions: If applicant is independent and no adaptations are needed – check the top box in each column to indicate, and proceed to following number.

1. Bathing: What assistance/adaptations does applicant require to safely and thoroughly bathe?

Independent	No adaptations
Set-up / Temperature Assistance	Grab bars
Prompts - Please specify: ____________________________ ____________________________	Shower seat – type/s: _____ ______________________
Physical Assistance - Please specify: ____________________ ____________________________	☐ Handheld showerhead
Dependent	Other: ________________

Bathing challenges/difficulties expected in camp environment? YES NO. If YES, please specify:

____

Independent	No adaptations
Set-Up / Weather Appropriateness Assistance	Adaptive clothing – please specify:
Prompts - Please specify:	Adaptive dressing equipment – please specify:
Physical Assistance - Please specify:	Avoid certain closures – please specify:
Dependent	Other:

In what position is applicant able to get dressed with greatest independence? ______________________

Dressing challenges/difficulties expected in camp environment? YES NO. If YES, please specify:

_____

~~3. Grooming: What assistance/adaptations does applicant require for success in grooming (deodorant, hair,~~ teeth, face etc.)?

Independent	No adaptations
Set-Up / Mirror / Visual Aide	Specific Toothbrush:
Prompts - Please specify:	Specific tool/item – Please specify:
Physical Assistance - Please specify:	Grasp support – Please specify:
Dependent	Other:

Dressing challenges/difficulties expected in camp environment? YES NO. If YES, please specify:

_____

DAILY LIFE INVENTORY

Applicant Name: ____

B. COMMUNICATION

If primary communication is verbal, please complete the following:

What % (approximate) of this applicant's speech would a new/unfamiliar person be able to understand? ___

If 100%, continue to section **C.** If less than 100%, complete the following: What concepts/words are difficult for applicant to communicate?

____

____

If primary communication is not verbal (gesture, device/tool, ASL), please complete the following:

How does applicant communicate 'YES'? ______________________________

How does applicant communicate 'NO'? ______________________________

What additional messages/concepts is applicant able to communicate? ______________________________

____

____

What type of device/tool does applicant use (if applicable)? ______________________________

Does applicant have difficulty making a choice? YES NO If YES, what support do they require, for success? ______________________________

____

How often is applicant able to complete a familiar request/direction (ex. close the door)? 0%-----50-----100%

C. FEEDING/EATING

1. Assistance and adaptations at mealtime – Check all that apply to applicant at a typical meal:

Independent during meals	No adaptations
Needs assist after tires/fatigues	Adaptive cup - Type: ____________
Needs set-up	Adaptive utensil - Type: ____________
Needs food in bite-size pieces	Adaptive plate - Type: ____________
Occasionally needs help with: ____________ ____________	Other Adaptation: ____________ ____________
Needs to be fed _______% of a typical meal	Straw

2. Chewing and Swallowing: Is applicant able to safely consume food orally (by mouth)? YES NO
Does applicant have any difficulty chewing or swallowing? YES NO. If YES, please specify:

____

Does applicant have any restrictions or alterations to their diet (swallowing/dysphagia protocol)? YES NO
If YES, please specify: ______________________________

____

3. Positioning/Support: Can applicant eat safely on a bench or stool, with no back support? YES NO (if YES, move to next box). What does applicant sit on while eating at home? ______________________________

If applicant is wheelchair user, are they able to pull up to average height (28-30") table? YES NO. If NO, what position/what setup are required? (ex. from tray table, in wheelchair) ______________________________

DAILY LIFE INVENTORY

Applicant Name: ____

____

4. Any interpersonal challenges for applicant at mealtime? ______________________
Do you foresee difficulties for applicant participating in a group eating environment, where traditional manners are emphasized? YES NO If YES, please specify: ______________________
____

D. INTERPERSONAL

1. When something unexpected happens, how does applicant react? ______________________
____

When upset, what support does applicant need to calm down? ______________________
____

What support does applicant need to be successful during a new/novel experience? ______________
____

2. Group living: participants live in cabins with 4-6 other people for the duration of the program, move around as a group and complete activities with many other people. Do you foresee any difficulties for this applicant with any aspect of group living? YES NO. If YES, please describe:
____

____

The information addressed in this section is sensitive. This information is important for us to provide a successful and safe program for participants. Concerns with/for applicant related to:

Fighting	Impulsivity	Personal space boundaries	Abuse
Quick to anger	Sexual behavior	Violence/aggression toward others	Suicidal ideation or attempt/s
Inappropriate verbal expression	Public masturbation	Self-harm	Property Destruction

Notes/Additional information: ____

3. **MOBILITY**

Primary method of mobility *indoors*: ______________________________________
Primary method of mobility *outdoors* (if different): _____________________________

Check boxes that apply to applicant regarding their level of independence and adaptations for mobility:

Independent	No Adaptations/equipment
Modified Independent (equipment used, but no supervision needed)	Orthotics/Braces – please specify type: _______ ______________________
Supervision	Forearm crutches
Arms-Length supervision	Walker
Prompts – please specify: ________________ ______________________	Cane Manual Wheelchair
Assistance – please specify: ______________ ______________________	Power Wheelchair Other: ______________________

DAILY LIFE INVENTORY

Applicant Name: ____

Bed Mobility: Is applicant able to independently get into and out of their bed? YES NO
If NO, please describe the assistance they require: ____

____

Is applicant able to move independently in bed for their comfort (roll, shift etc.)? YES NO
If NO, please describe the assistance they require: ____

____

Transfers: moving from one surface to another.
Circle level of independence during typical transfer:
Independent Supervision Stand-By Assist Contact Guard Assist Minimum – Moderate Assist

Describe transfer method used (position, tips etc.): ____

____

____. *To promote safety for participants and staff –due to the short duration of training- we are not able to support participants who require maximum assist during transfers, dependent transfers, two-person assistance or Hoyer lifts.*

4. SLEEP

Typical, twin-size beds (wooden bunk-bed style) are provided for participants and staff to sleep on.
Does applicant typically require assistance during sleeping hours? YES NO. If YES, please specify:

____

Sleep challenges/difficulties expected in camp environment? YES NO. If YES, please specify:

____

5. TOILETING / CONTINENCE / PERSONAL HYGIENE

Directions: Check all boxes that apply to applicant, and include additional information if indicated.

No Assistance or prompts	No equipment needed
Reminders (wash hands, use toilet, schedule)	Brief – please specify size: ____________________
Assistance wiping	Wipes
Prompts – please describe: ________________ ____	Adaptive seating – please specify: ______________ ____
Assistance – please describe: ______________ ____	Catheters/adaptive toileting equipment – please specify:______________________________
Dependent	Seat Belt / Gait Belt

Toileting challenges/difficulties expected in camp environment? YES NO. If YES, please specify:

____

Feminine Hygiene - for menstruating females: does applicant require assistance/prompting to manage her period? YES NO N/A If YES, please specify:

____

____

Call or email with any questions: ***Tori Grovas,*** (906)345-9314 or baycliff@baycliff.org