|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Social Sec. #: |  |
|  |
| Date of Birth: |  | Medicaid #: |  |
|  |
| Address: |  |
|  |
|  |
|  |
| Social Worker / Case Manager / Service Coordinator: |  |
|  |
| Agency: |  | Phone: |  | Fax: |  |
|  |
| Address: |  |
|  |
|  |
|  |
| Overview of Individual’s Current Status: |  |
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| --- | --- | --- |
| ***For J & M Office Use Only:*** | House: |  |
|  |
| Trial Visit Date: |  | Outcome: |  |
|  |
| Admission Date: |  | Level of Care:  |  | Skilled |  | Intermediate |
|  |
| Notes: |  |
|  |  |
|  |
|  |
|  |
|  |
| Discharge Date: |  | Reason: |  |
|  |  |  |  |  |  |  |  |  |  |
| Discharged to: |  | Group Home |  | Hospital |  | Sponsored Residential |
|  |
|  |  |  | Other – Explain: |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Prepared By: |  | Title: |  |
|  |
| Phone: |  | Other Phone: |  | Date: |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
| **DSS Section** (Check / Complete All That Apply): |
|  |
|  |  | Eligible for Full Medicaid Services Beginning: |  |
|  |
|  |  | Eligible for Medicaid Services Beginning: |  |
|  |
|  |  | Eligible for QMB Medicaid Only |
|  |
|  |  | Ineligible for Medicaid Payment of LTC services from |  | Due to Asset . . .  |
|  |
|  |  | . . . Transfer | Note: |  |
|  |
|  |  | Eligible for Medicare Premium Payment Only |
|  |
|  |  | Has Medicare Insurance |
|  |
|  |  | Has Other Health Insurance | Specify: |  |
|  |
|  | Patient Pay Amount:  |  |
|  |
| Comments / Clarifications: |  |
|  |
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| --- | --- | --- |
| **Health and Medical Section:** |  |  |
|  |  |  |  |
| Primary Diagnosis / Disability: |  |
|  |
| Secondary Diagnosis / Disability: |  |
|  |
| Tertiary Diagnosis / Disability: |  |
|  |  |  |  |
| Intellectual Disability Level: |  |  |
|  |  |  |  |
|  | Borderline |  | Mild |  | Moderate |  | Severe |  | Profound |
|  |  |  |  |

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| --- | --- | --- | --- |
| Date of last completed UAI: |  | Date of last TB test: |  |
|  |  |  |  |
| Date of last physical: |  | Date of last dental visit: |  |
|  |  |  |  |

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| --- |
| **Current Medication Information** (Attach additional page if needed): |
|  |
|  | Medication(s): | Dosage: | Time: | Reason for Taking: |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| 6 |  |  |  |  |
| 7 |  |  |  |  |
| 8 |  |  |  |  |
| 9 |  |  |  |  |
| 10 |  |  |  |  |
| 11 |  |  |  |  |
| 12 |  |  |  |  |
| 13 |  |  |  |  |
| 14 |  |  |  |  |
| 15 |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Self-Administered: |  | Yes |  | No | Comments: |  |
|  |  |  |  |  |
| Allergies (If applicable): |  |
|  |
|  |
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|  |
|  |
| Ambulatory: |  | Yes |  | No | Comments: |  |
|  |
| Hearing Impaired: |  | Yes |  | No | Comments: |  |
|  |
| Visually Impaired: |  | Yes |  | No | Comments: |  |
|  |  |  |  |  |
| Assistive Technology Used: |  |
|  |
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|  |
| Current Medical Concerns: |  |
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| Current Treatments: |  |
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| Past Serious Injuries / Illnesses: |  |
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| Hospitalizations / Dates / Reasons: |  |
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| --- | --- | --- | --- |
| Primary Care Physician: |  | Specialty: |  |
|  |
| Address: |  |  |  |  |  |
|  |
| Phone #: |  | Fax #: |  | E-Mail: |  |
|  |
|  |
|  |
| Other Physician: |  | Specialty: |  |
|  |
| Address: |  |  |  |  |  |
|  |
| Phone #: |  | Fax #: |  | E-Mail: |  |
|  |
|  |
|  |
| Other Physician: |  | Specialty: |  |
|  |
| Address: |  |  |  |  |  |
|  |
| Phone #: |  | Fax #: |  | E-Mail: |  |
|  |
|  |
|  |
| Psychiatrist: |  | Specialty: |  |
|  |
| Address: |  |  |  |  |  |
|  |
| Phone #: |  | Fax #: |  | E-Mail: |  |
|  |
|  |
|  |
| Dentist: |  | Specialty: |  |
|  |
| Address: |  |  |  |  |  |
|  |
| Phone #: |  | Fax #: |  | E-Mail: |  |

|  |
| --- |
| **Substance Abuse History** |
|  |
| Substance: | Ever Used: | Amount / Frequency: |  | Method: |  | Last Used: |
|  |  |  |  |  |  |  |  |  |  |
| Alcohol |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Marijuana |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Cocaine |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Heroin |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Inhalants |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Barbiturates |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Tranquilizers |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Hallucinogens |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Other Substances (Explain): |  |
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| **Behavioral Challenges** |
|  |
| Behavior: | During last year: | Frequency: |  | Triggers / antecedents: |
|  |  |  |  |  |  |  |  |
| Hit Others |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Kick Others |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Pinch Others |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Spit at Others |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Pull Others Hair |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Bite Others |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Hit Self |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Pinch Self |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Bite Self |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Other Self-Abuse |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Property Damage |  | Yes |  | No |  |  |  |
|  |  |  |  |  |  |  |  |
| Setting Fires |  | Yes |  | No |  |  |  |
|  |
| Other Behaviors (Explain): |  |
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| **Personal Talents / Skills:** |
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| **Personal Weakness / Areas for Growth:** |
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| **Governmental Financial Aid:** |  |  |  |  |  |
|  |  |  |  |  |  |
| Source: | In Past Month: | Amount: |
|  |  |  |  |  |  |
| SSI |  | Yes |  | No |  |
|  |  |  |  |  |  |
| DSSI |  | Yes |  | No |  |
|  |  |  |  |  |  |
| Medicaid |  | Yes |  | No |  |
|  |  |  |  |  |  |
| WIC (Food Stamps) |  | Yes |  | No |  |
|  |  |  |  |  |  |
| Other: |  | Yes |  | No |  |
|  |  |  |  |  |  |
| Other: |  | Yes |  | No |  |
|  |  |  |  |  |  |
| Other: |  | Yes |  | No |  |

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Is the individual currently approved for Medicaid Waiver? |  | Yes |  | No |
|  |  |  |  |  |
| Current Waiver Services: |  |
|  |  |
| How many hours of services were needed in current placement? |  |
|  |  |

Before admission the following items will be needed:

* Original Social Security Card
* Medicaid Card
* Original Birth Certificate
* Psychological Evaluation (Current within 3 years)
* Current Physical Examination
* Current SIS
* Current LOF (Level of Functioning)
* Current Behavioral Support Plan (If applicable)
* Current Authorized Representative or Guardianship Documents (If applicable)

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| --- |
| **Key Things to know about the individual:** |
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| **Important things to know to help the individual succeed and be happy:** |
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| --- | --- | --- |
|  |  |  |
| Signature of Person Completing Form: |  | Date: |
|  |  |  |
|  |  |  |
| Title of Person Completing Form: |  | Relationship to Individual: |
|  |  |  |
|  |  |  |
| Signature of J & M Administrator Reviewing Form |  | Date: |
|  |  |  |