|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | | | | | Social Sec. #: |  | | |
|  | | | | | | | | | | |
| Date of Birth: | | |  | | | | Medicaid #: |  | | |
|  | | | | | | | | | | |
| Address: | |  | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Social Worker / Case Manager / Service Coordinator: | | | |  | | | | | | |
|  | | | | | | | | | | |
| Agency: |  | | | | Phone: | |  | | Fax: |  |
|  | | | | | | | | | | |
| Address: | |  | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Overview of Individual’s Current Status: | | | | | |  | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***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: | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | |  |  | |  |  | |  | | |  | |  | | |  |  |
|  | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health and Medical Section:** | | | | | | | |  | | | |  | |
|  | | | |  | | | |  | | | |  | |
| Primary Diagnosis / Disability: | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | |
| Secondary Diagnosis / Disability: | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | |
| Tertiary Diagnosis / Disability: | | | | | |  | | | | | | | |
|  | | | | | |  | |  | | | |  | |
| Intellectual Disability Level: | | | | | | | |  | | | |  | |
|  | | | |  | | | |  | | | |  | |
|  | Borderline |  | Mild | |  | | Moderate | |  | Severe |  | | Profound |
|  | | | |  | | | |  | | | |  | |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Self-Administered: | |  | Yes | | |  | | No | | Comments: | |  | | |
|  | |  | | | | | | | |  | | |  |  |
| Allergies (If applicable): | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Ambulatory: |  | Yes | | |  | | No | | Comments: | |  | | | |
|  | | | | | | | | | | | | | | |
| Hearing Impaired: | |  | Yes | | |  | | No | | Comments: | |  | | |
|  | | | | | | | | | | | | | | |
| Visually Impaired: | |  | Yes | | |  | | No | | Comments: | |  | | |
|  | |  | | | | | | | |  | | |  |  |
| Assistive Technology Used: | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Current Medical Concerns: | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Current Treatments: |  | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| Past Serious Injuries / Illnesses: | |  | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| Hospitalizations / Dates / Reasons: | | |  |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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): | | |  | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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): | | |  | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |

|  |
| --- |
| **Personal Talents / Skills:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |
| --- |
| **Personal Weakness / Areas for Growth:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | |  |  |  |  |
| 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)

|  |
| --- |
| **Key Things to know about the individual:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |
| --- |
| **Important things to know to help the individual succeed and be happy:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | |  |  |
| Signature of Person Completing Form: | | |  | Date: |
|  | | |  |  |
|  |  |  | | |
| Title of Person Completing Form: |  | Relationship to Individual: | | |
|  | | |  |  |
|  | | |  |  |
| Signature of J & M Administrator Reviewing Form | | |  | Date: |
|  | | |  |  |