IDF for Delaware Users

Individual: _____ Entered By: _____
Date: _____ Time _____ am / pm

Identification Data

First Name:* _____ Last Name:* _____
Middle Name: _____ Suffix: _____
SSN: _____ Birth Date: _____ Goes By:_____

Photo

Photo 1 ☐ Attached Photo Date: _____

Photo 2 ☐ Attached Photo Date: _____

Gender: ☐ Male ☐ Female ☐ Unknown

Medicaid Number _____

ID Type: ☐ DE, Delaware, Accounting ID Number ☐ DE, DE, DDDS-MCI#
☐ DE, DE, Medicaid Number ☐ DE, Delaware, Registry

ID Number: _____

Additional ID Type: ☐ DE, Delaware, Accounting ID Number ☐ DE, DE, DDDS-MCI#
☐ DE, DE, Medicaid Number ☐ DE, Delaware, Registry

Additional ID Number: _____

Hair Color:
☐ Black ☐ Blonde ☐ Brown ☐ Brown-dark ☐ Brown-light ☐ Brunette ☐ Gray ☐ Red ☐ White ☐ Other _____

Eye Color:
☐ Black ☐ Blue ☐ Brown ☐ Gray ☐ Green ☐ Hazel ☐ Other _____

Ethnicity/Hispanic Origin:
☐ Central American ☐ Cuban ☐ Hispanic ☐ Mexican ☐ Not Hispanic or Latino ☐ Other Spanish Origin ☐ Puerto Rican ☐ South American ☐ Unable to Determine

Race:
☐ American Indian/Alaskan Native ☐ Asian ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Declined ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian/Other Pacific Islander ☐ Samoan ☐ Undetermined ☐ Unknown ☐ Vietnamese ☐ White ☐ Other

Height: _____Feet _____Inch **Weight Range:** From _____ lbs To _____ lbs

Characteristics:_____
_____
_____
_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
Note: - Required fields are marked with an asterisk (*)

Interpreter Needed:
☐ Yes ☐ No ☐ Unknown

Primary Written Language:
☐ American sign Language ☐ Arabic ☐ Armenian ☐ Bengali ☐ Bosnian ☐ Chinese (Mandarin) ☐ Cambodian ☐ Creole ☐ Danish ☐ English ☐ French ☐German☐ Hebrew ☐ Hungarian ☐ Italian ☐ Japanese ☐ Korean ☐ Kurdish ☐ Laotian ☐ Latvian ☐Marshallese ☐Native American ☐ Norwegian ☐ Polish☐ Portuguese ☐ Romani ☐ Romanian ☐ Russian ☐ Serbo-Croatian☐ Sign Language - SeeII ☐ Sioux ☐ Somali ☐ Spanish ☐ Sudanese ☐Swedish ☐ Ukrainian ☐ Vietnamese ☐ Other_____

Primary Oral Language:
☐ American sign Language ☐ Arabic ☐ Armenian ☐ Bengali ☐ Bosnian ☐ Chinese (Mandarin) ☐ Cambodian ☐ Creole ☐ Danish ☐ English ☐ French ☐ German ☐ Hebrew ☐Hungarian ☐Italian ☐Japanese ☐Korean ☐Kurdish ☐Laotian ☐Latvian ☐ Marshallese ☐Native American ☐ Norwegian ☐ Polish ☐ Portuguese ☐ Romani ☐ Romanian ☐ Russian ☐ Serbo-Croatian ☐ Sign Language - SeeII ☐ Sioux ☐ Somali ☐ Spanish ☐ Sudanese ☐ Swedish ☐ Ukrainian ☐ Vietnamese ☐ Other_____

Individual's Time Zone:*
☐ US/Samoa ☐ US/Aleutian ☐ US/Hawaii ☐ US/Alaska ☐ US/Pacific ☐ US/Pacific-New ☐ US/Arizona ☐ US/Mountain ☐ US/Central ☐ US/East-Indiana ☐ US/Eastern ☐ US/Indiana Starke ☐ US/Michigan ☐ Pacific/Guam ☐ America/Puerto-Rico ☐ Asia/Bangkok ☐ Asia/Colombo ☐ Asia/Dhaka ☐ Asia/Jakarta ☐ Asia/Kathmandu ☐ Asia/Kolkata ☐ Asia/Kuala-Lumpur ☐ Asia/Manila ☐ Asia/Phnom-Penh ☐ Asia/Singapore ☐ Asia/Thimphu

Citizenship:
☐ USA ☐ Canada
☐ Other_____

Marital Status:
☐ Divorced ☐ Married
☐ Separated ☐ Single
☐ Unknown ☐ Widowed

Religion:
☐ Baptist ☐ Buddhist ☐ Catholic ☐ Church of Latter Day Saints ☐ Eastern Orthodox ☐ Episcopal ☐ Greek Orthodox ☐ Hindu ☐ Jewish ☐ Lutheran ☐ Lutheran - ELCA ☐ Lutheran - ELS ☐ Lutheran - LCMS ☐ Lutheran - Other ☐ Lutheran - WELS ☐ Methodist ☐ Mormon ☐ Muslim ☐ Nazarene ☐ Presbyterian ☐ Protestant ☐ Seventh Day Adventist ☐ Other_____

Marital Status Date: _____ Admission Date: _____
Date of Discharge: _____ Date of Death: _____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
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Living Arrangement:

☐ Apartment or House ☐ Assisted Living ☐ Assisted Living - Waiver ☐ Battered Women & Child Shelter ☐ Board And Room ☐ Campus Housing - Meals Not Provided ☐ Campus Housing - Meals Provided ☐ Certified Adult Family Home ☐ Child Caring Agency ☐ Community ☐ ETLA- Emergency Transition Living Arrangement ☐ Family Home ☐ Foster Care ☐ Group Home ☐ Halfway House ☐ Homeless Shelter ☐ Hospital - Acute Hospital Care ☐ IRA ☐ Independent Living ☐ Institution - Psychiatric Care - IMD ☐ Intermediate Care Facility for ID/DD ☐ Licensed Center for Developmentally Disabled ☐ Licensed Community Care ☐ Licensed Domiciliary Facility ☐ Licensed Drug Treatment Center ☐ Licensed Mental Health Center ☐ Licensed Residential Care Facility ☐ Living with Guardian of Child ☐ Living with Parent ☐ Living with Relative ☐ Nursing Home ☐ Other ☐ Other Residential ☐ PCS Home ☐ Public Housing ☐ Room Only ☐ Supported Living Arrangement ☐ Supported Living

Class Membership: _____

Active Program & Site Information:

Program Name	Enrollment Date	Site Name	Address	Primary Contact	Secondary Contact

Discharged Program & Site Information:

Program Name	Enrollment Date	Discharged Date	Site Name	Address	Primary Contact	Secondary Contact

Residential Address:

Residential Program/Site_____

Attention or in care of: _____

Street 1: _____ Street 2: _____

Country: _____ State: _____

City: _____ County: _____

Zip: _____

Primary Phone: _____ Secondary Phone: _____

Additional Phone: _____

Mailing Address:

☐ Same as Residential Address

Attention or in care of: _____

Street 1: _____ Street 2: _____

Country: _____ State: _____

City: _____ County: _____

Zip: _____

Primary Phone: _____ Secondary Phone: _____

Additional Phone: _____

Birth Place:

Country: _____ State: _____

City: _____ Other: _____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

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Medical Information:
Emergency Orders:

_____
_____
_____
Adaptive Equipment:
_____
_____
_____

Blood Type: ☐ A+ ☐ A- ☐ B+ ☐ B- ☐ AB- ☐ AB+ ☐ O+ ☐ O- ☐ Unknown

Active Diagnoses:

ICD - 10	DSM - 5	ICD - 9 / DSM -4 / Other	Axis	Description	Diagnosis Date	Diagnosed By

Primary Diagnosis: _____

Developmental Disability: ☐ Cerebral Palsy ☐ Epilepsy ☐ Autism ☐ Neurological Impairment ☐ Other

Intellectual Disability: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Unspecified

Primary Care Physician: _____
Other Medical Information: _____
_____
_____
Allergies:
_____
_____
_____
Advance Directives:

Preferred Intervention for Known Condition	☐ Yes	☐ No	Date:_____
DNR Order	☐ Yes	☐ No	Date:_____
Living Will	☐ Yes	☐ No	Date:_____
Durable Power of Attorney for Health Care	☐ Yes	☐No	Date:_____
Advance Directive	☐ Yes	☐ No	Date:_____

Comments: _____

Dietary Guidelines: _____
_____
_____
Eating Guidelines:_____
_____
_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
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Communication Modality: ☐ Communication Device ☐ Non-Verbal ☐ Partially Verbal ☐ Sign ☐ Verbal ☐ Other
Other: _____

Communication Comments:_____
_____
_____

Mobility: ☐ Uses a cane ☐ Uses walker ☐ Walks on own ☐ Walks with assistance ☐ Wheelchair ☐ Other_____

Mobility Comments:_____
_____
_____

Supervision: ☐ 1:1 ☐ Arm's Length ☐ Assistance for everything ☐ Assistance for personal care ☐ Determined by Family ☐ Independent ☐ Line of sight ☐ Never unattended ☐ No supervision ☐Range of Scan ☐ Supervision for personal care ☐ Visual Scan ☐ Other _____

Supervision Comments: _____
_____
_____

Food Texture: ☐ Whole or Normal Consistency ☐ Food consistency altered-Chopped ☐ 1" Pieces Cut to Size ☐ 1/2" Pieces Cut to Size ☐ 1/4" Pieces Cut to Size ☐ Ground ☐ Pureed ☐ Food consistency altered-Uses Thickener ☐ Nothing by mouth-NPO

Liquid Consistency: ☐ Thin ☐ Nectar ☐ Honey ☐ Pudding

Referral Source:_____
_____
_____

Toileting Status: ☐ Incontinent/Requires Disposable Briefs ☐ Requires Physical Assistance/Equipment ☐ Requires Prompts/Monitoring ☐ Scheduled Bladder Program ☐ Scheduled Bowel Program ☐ Toilets Independently

Guardian of Self:	**Mealtime Status:**	**Bathing Status:**
☐ Yes ☐ No ☐ Unknown	☐Eats Independently (with or without adaptive equipment)	☐ Independent
	☐ Requires Support to Eat	☐ Requires Support to Bath/Shower
	☐ Requires Physical Assistance/Equipment	☐ Independent with Devices
	☐ Requires Positioning Equipment	

☐ Do not notify Family/Guardian as there is written advice that they do not want to be notified for incidents defined as Reportable(Medium notification level), Serious Reportable(High notification level) or have Abuse/Neglect specified.

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
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Contacts

Individual Contacts:

Name	Contact Type	Agency	Address	Mailing Address	Action

Shared Contacts:

Name and Organization Name	Specialty And Contact Type	Address	Mailing Address	Action

Insurance

Medicare Number: _____ Medicare Effective Date: _____

Medicare Section: ☐ A ☐ B ☐ A and B

Medicare:

Med Plan D Id: _____ Med Plan D Plan Name: _____

Med Plan D Issuer: _____ Med Plan D RxBIN: _____

Med Plan D RxPCN: _____ Med Plan D RxGRP: _____

Other Benefits: _____

_____

_____

Other Insurance:

Insurance Company: _____ Insurance Group: _____

Insurance Policy Number: _____ Insurance Policy Holder: _____

Behavior:

Behavior Management: _____

_____

_____

Assessment Score:

Assessment Type	Score	Band/Percentile	Assessment Date	File	Comments	Action

Team Members:

Name	Relationship

Pending Admission Notes: _____

_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

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