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Individual Data Form

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: ______________________ ID Number: ______________________
Additional ID Type: ______________________ 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 (*)

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Interpreter Needed:	**Primary Written Language:**	**Primary Oral Language:**
☐ Yes ☐ No ☐ Unknown	☐ 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___________	☐ 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:*	**Citizenship:**	**Religion:**
☐ 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	☐ USA ☐ Canada ☐ Other___________ **Marital Status:** ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Unknown ☐ Widowed	☐ 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: __________________

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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: ____________________

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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:____
____
____

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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) ☐ Requires Support to Eat ☐ Requires Physical Assistance/Equipment ☐ Requires Positioning Equipment	☐ Independent ☐ Requires Support to Bath/Shower ☐ Independent with Devices

☐ 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.

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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

Consent Record List:

Consent Name	Consent Type	Consent Status	Effective From	Effective To	Action

Team Members:

Name	Relationship

Pending Admission Notes: ____

____

Custom Fields:

1.
2.
3.
4.
5.

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