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: _____

Race:
☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Other

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

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

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

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

Primary Oral Language:
☐ English ☐ French ☐ Spanish ☐ Other ☐ Other _____

Primary Written Language:
☐ English ☐ French ☐ Spanish ☐ Other ☐ Other _____

Interpreter Needed:
☐ Yes ☐ No ☐ Unknown

Religion:
☐ Baptist ☐ Buddhist ☐ Catholic ☐ Church of Latter Day Saints ☐ Eastern Orthodox ☐ Episcopal ☐ Greek Orthodox ☐ Hindu ☐ Jewish ☐ Lutheran ☐ Methodist ☐ Mormon ☐ Muslim ☐ Nazarene ☐ Presbyterian ☐ Protestant ☐ Seventh Day Adventist ☐ Other
Other _____

Citizenship:
☐ USA ☐ Canada ☐ Other
Other _____

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

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 ☐ Other

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

Living Arrangement:

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

Note:- Required fields are marked with an asterisk (*)

□ 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 □ ELTA- 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

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: _____

Medical Information:

Emergency Orders: _____

_____

Adaptive Equipment: _____

_____

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

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

Note:- Required fields are marked with an asterisk (*)

Active Diagnoses:

Axis	Description	Code	Diagnosed By	Diagnosis Date	Resolved By	Resolve Date	Created By	Last Updated By

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:_____

Dietary Guidelines: _____
_____
Eating Guidelines: _____
_____

Communication Modality: ☐ Communication Device ☐ Non-Verbal ☐ Partially Verbal ☐ Sign ☐ Verbal ☐ Other
Other: _____

Communication Comments: _____
_____

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

Mobility Comments: _____
_____

Supervision: ☐ No Supervision ☐ Supervision for personal care ☐ Assistance for everything ☐ Arm's Length ☐ Line of sight ☐ Assistance for personal care ☐ Never unattended ☐ Othe ☐Other _____

Supervision Comments: _____
_____

Food Texture: ☐ Whole or Normal Consistency ☐ Food consistency altered-Chopped ☐ 1'' Pieces Cut to Size ☐ 1/2'' Pieces Cut to Size ☐ Ground ☐ Puree ☐ Food consistency altered-Uses Thickness
Liquid Consistency: ☐ Thin ☐ Nectar ☐ Honey ☐ Pudding

Referral Source: _____
_____

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

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

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

☐ 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.

Contacts

Individual Contacts:

Name	Contact Type	Agency	Address	Mailing Address

Shared Contacts:

Name and Organization Name	Specialty And Contact Type	Address	Mailing Address

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: _____
_____
_____

Custom Fields:

1.
2.
3.
4.
5.

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