I. Essential Information

Maintained and shared with the support coordinator and providers for accessing services and promoting personal health and safety in accordance with Medicaid and Licensing regulations.

Contact Information

Legal Name:		**Preferred Name:**	
Date of Birth:		**Gender:**	
Medicaid #:		**Medicare #:**	
Home Street Address:		**Other Medical Insurance:**	
Mailing Address or P.O. Box:		**SSN#:**	
City:		**Zip Code:**	
Home phone:		**Cell phone:**	
Work phone:		**Email address:**	
		Preferred Language:	

Emergency Contacts / Representation

Name	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Legal Guardian:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Authorized Rep:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Family #1:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Family #2:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Family #3:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Power of Attorney:	**Phone:**	**Fax:**	**Email:**
Relationship/Type:	**Address**:		
Emergency Contact:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Conservator:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Representative Payee:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		

I. Essential Information

Physician 1:	**Phone:**	**Fax:**	**Email:**
Specialty:	**Address**:		
Physician 2:	**Phone:**	**Fax:**	**Email:**
Specialty:	**Address**:		
Physician 3:	**Phone:**	**Fax:**	**Email:**
Specialty:	**Address**:		
Physician 4:	**Phone:**	**Fax:**	**Email:**
Specialty:	**Address**:		
Dentist:	**Phone:**	**Fax:**	**Email:**
Address:			
Other:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		
Other:	**Phone:**	**Fax:**	**Email:**
Relationship:	**Address**:		

Support Coordination and Provider Contacts

Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
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Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**
Support Role:	**Agency:**	
Name:		**Address:**
Phone:	**Fax:**	**Email:**

I. Essential Information

Other information:

Burial Plan:	I have a burial plan? Yes or No	Location
Life Insurance	I have Life Insurance? Yes or No	Location:
Funeral home preference	:I have a preplanned funeral? Yes or No	Name: Address Phone

Photo ID:

Date Photo taken: _____

I. Essential Information

Communication and Sensory Support –

Preferred language:	Please *check one*) ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (Please Specify):
Describe supports needed for communication (if any):	
Do I have any difficulty reading a magazine or newspaper?	☐ Yes ☐ No If *yes*, please describe.
Would a professional evaluation related to sensory or communication abilities be beneficial?	☐ Yes ☐ No

Adaptive Equipment, Assistive Technology and Modifications

Please describe any adaptive equipment and assistive technology supports (if any):	
Would a professional evaluation related to adaptive equipment, assistive technology or other modifications be beneficial?	☐ Yes ☐ No

Health Information

Do you have an advanced directive?	☐ Yes ☐ No <u>If yes, please provide a copy to all relevant parties</u>.
Do you have a Do No Resuscitate(DNR) Directive?	☐ Yes ☐ No <u>If yes, please provide a copy to all relevant parties</u>.

I. Essential Information

Medication/treatments	Physician:		Reason(s) prescribed:
Dosage:	Route:	Frequency:	Location of potential side effect information:
1:			
2:			
3:			
4:			
5:			
6:			
7:			
8:			
9:			
10:			

HEALTH TOPIC	DESCRIPTON
Date of my last complete physical exam.	Date:
Date of my last dental exam.	Date:
Do I have any mental health support needs?	☐ Yes ☐ No Please provide crisis plan (if applicable) and describe support needs:
Do I have any allergies to medication, food, or environmental elements (e.g., mold, dust, etc.)?	☐ Yes ☐ No If yes, please describe:
Please describe all recent physical complaints & medical conditions.	
Do I have any issues with physical intimacy, pregnancy or child rearing?	☐ Yes ☐ No If *yes*, please describe:
Do I have any chronic health conditions?	☐ Yes ☐ No If *yes*, please describe:
Do I have any communicable diseases?	☐ Yes ☐ No If *yes*, please describe:
Do I have any limitations or restrictions on physical activities?	☐ Yes ☐ No If *yes*, please describe:

I. Essential Information

Have I had any serious illnesses, serious injuries, and/or hospitalizations in the past?	☐ Yes ☐ No If *yes*, please describe:
Have there been any serious illnesses or chronic conditions among my parents, siblings, or grandparents?	
**Have there been any serious illnesses or chronic conditions among significant others in my household (if any)? Question would this not get into privacy issues with others in a congregate living situation? (e.g. 4 bed house)?	
Have I ever smoked cigarettes/cigars or used smokeless tobacco?	☐ Yes ☐ No If *yes*, please describe:
a. How often do I drink alcohol? b. Does my current use of alcohol cause problems in any area of my life? Have I ever been told that I drink too much alcohol	*a.* Number of times and number of drinks per week: *b.* ☐ Yes ☐ No If *yes*, please describe:
a. Does my current use of prescription medication cause problems in any area of my life? b. Have I found that I have to take more and more of any prescription medication to feel an effect? c. Have I ever been told that I take my medications incorrectly.	*]*
Have I ever been in treatment for a problem with, or resulting from, use of alcohol, drugs, or prescription medicine?	.☐ Yes ☐ No If *yes*, please describe *what type of treatment, was provided and when.*
Is there any other health history or medical information or health preferences that I would like to share?	

Summary of Social/Developmental/Behavioral/Family History

Briefly describe my relevant social, developmental, behavioral and family history.	

I. Essential Information

Summary of Employment and Educational Background

Education: ☐ None ☐ Elementary ☐ Middle School ☐ Some High School ☐ High School

☐ Vocational ☐Some College ☐ College degree ☐ Some Graduate School

☐ Masters Degree or Higher

Current Employment status: ☐ Unemployed, but want to work ☐ Unemployed, not able to or interested in work ☐ Employed, Part-Time ☐ Employed, Full-time ☐ Retired

Describe my educational history.	
Describe my employment history.	
Describe any volunteer activities in which I now am involved or have been involved in the past (if any).	**Note:** Please include the types of things I did, the organization(s) involved, and when I volunteered.

Exceptional Support Needs

Were any support needs identified on the risk assessment (Supports Intensity Scale Section IV) or elsewhere in my information?	☐ Yes ☐ No If yes, please provide a description of each support need below: 1) 2) 3) 4) 5)
Is there a behavioral or crisis support plan?	☐ Yes ☐ No
** Meet criteria for high intensity day support?	☐ Yes ☐ No If yes, please describe:

I. Essential Information

Ability to Access Services and Supports

What concerns do I have about being able to access services and/or supports?	☐ Yes ☐ No If *yes*, please provide a description and a plan to resolve the concern(s):

Legal and Advocacy

** Do I have any current legal issues or problems?	☐ Yes ☐ No If *yes,* please describe:
** Do I need any legal advice?	☐ Yes ☐ No If *yes*, please describe:
Do I need any support with voting? (Understanding my rights, registering or voting)	☐ Yes ☐ No If *yes*, please provide brief description of how I will be supported:

Eligibility

Level of Functioning Survey	Date completed: Categories met: ☐ Health Status ☐ Communication ☐ Task Learning Skills ☐ Personal/Self Care ☐ Mobility ☐ Behavior ☐ community Living
Diagnosis of MR ?	☐ Yes ☐ No Date psychological completed:
If under 6, at developmental risk?	☐ Yes ☐ No Date evaluation completed:

Back-up** and / or Discharge Plan

** Am I receiving a Medicaid Home and Community Based Waiver?	☐ Yes ☐ No If *Yes*, please identify which Waiver: ; and please describe or attach my back-up plan.
Describe any transition/discharge plans for any services I currently receive (if applicable).	

Essential Information completed by:

I. Essential Information

Review or Revision Date: _____

Name (print):_____

Signature:_____ **Title:** _____ **Date:** _____ **3**

NOTE: Asterisks denote areas which are only required for the provider listed below:
* ICFMR providers only
** waiver programs only