J & M Adult Care Services, LLC

Admissions Form

"Your Home Away From Home"

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: _____

J & M Adult Care Services, LLC

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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: _____

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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: _____

_____

_____

_____

_____

_____

_____

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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		

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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? _____

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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:

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