Developmental Achievement Center

515 5th Ave. S.
Crookston, MN 56716
Phone 218-281-4181
Fax 218-281-2678
dac@midconetwork.com

1011 11th Ave. S.
East Grand Forks, MN 56721
Phone 218-773-0530
Fax 218-773-0443
egfdac@rrv.net

Attatchment C

ADMISSION FORM AND CLIENT DATA

Name: ______________________ **Admission Date:** ______________________

Address: ______________________ **Sex (M or F)** __________

______________________ **Client Date of Birth:** ______________________

______________________ **Diagnosis:** ______________________

Parent's Name: ______________________ ______________________

Parent's Address: ______________________ ______________________

______________________ **Parent's Phone # :** ______________________

______________________ **Cell Phone # :** ______________________

Email Address: __________________________

Guardian's Name (If Different from the Parents): ______________________

Relationship: ______________________ **Guardian's Phone # :** ______________________

Guardian's Address: ______________________

______________________ **Cell Phone # :** ______________________

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Email Address: __________________________

M.A. # ________________ **Religious Preference:** ______________________

Health Insurance Company (If Applicable): ______________________

Policy #: ________________ **SSN:** ______________________

In Case of Emergency Notify: 1 ____________________ **Phone # :** ______________________

2 ____________________ **Phone # :** ______________________

Name of Physician: ______________________ **Phone # :** ______________________

Address/Clinic: ______________________

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Hospital of Preference: ______________________ **Phone # :** ______________________

Address: ______________________

____

Name of Dentist: ______________________ **Phone # :** ______________________

Address: ______________________ **Dentures?:** ______________________

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Case Manager's Name: ______________________ **Phone # :** ______________________

Address: ______________________

____

Email Address: ______________________

County of Financial Responsibility: ______________________

If living in a residential facility, name of facility, administrator/director or owner: ______________________

____

Address: ______________________ **Phone # :** ______________________

______________________ **Cell # :** ______________________

Email Address: ______________________

Other Licensed agencies that serve this consumer: ______________________

____

Address(s): ______________________

____

Contact Person(s): ______________________

Immunization Record (Attach if necessary): Please list Tetnus, Hepatitus B etc.: ______________________

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Describe any physical disabilities: ______________________

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Describe any behavioral problems (please be specific): ______________________

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Does this person get angry? (If so, please list any antecedents or things that often trigger anger):

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____

____

Any dietary needs?(Calories, no caffeine, low cholesterol/fat, texture, liquids, etc.):

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____

____

Height: ____________ **Weight:** ____________ **Ideal Weight Range:** ____________

Hearing (Good/Bad): ____________ **Hearing Aids?:** ____________ **Glasses?:** ____________

Allergies: ______________________

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History of Seizures?: ____________ **List types:** ______________________________

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Please describe a typical seizure: ______________________________

____

Describe any vocational skills (learns by doing/observing, prefers repetition, list any adaptations):

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____

Past vocational tasks/worksites: ______________________________

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Vocational Interests: ______________________________

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Vocational Dislikes: ______________________________

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Communication (ability to talk, read/write, sign, augmentative device, computer skills, etc.):

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Math and Money skills (Please describe the person's level of functioning): ______________

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Social and Community Skills (Ability to hold appropriate conversations, Greets others, To order independently, Pedestrian Safety Skills, Table Manners, etc.): ______________________________

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Any Other Pertinent Information that would be useful without having prior met this person:

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Would you like a client money account set up at the DAC? **(Usually for clients that cannot safely handle money)** ________

Print Name of Person Supplying this Information: ______________________________

Signature of Person Supplying this Information: ______________________________

Date Information Supplied: ______________________

For Person's File: (For Office Use Only)

Copy of a Current Individual Service Plan (ISP):	Yes: ______________	No: ______________
Health Exam (No more than 1 year old) by M.D.:	Yes: ______________	No: ______________
Release of Information Signed by Guardian:	Yes: ______________	No: ______________
Risk Management Plan Completed and Signed the : day of Admission:	Yes: ______________	No: ______________
Formal Referral Made (Attachment A):	Yes: ______________	No: ______________
Copy of Immunization Record:	Yes: ______________	No: ______________
List of Current Medications and (if necessary) an Authorization form signed if meds are to be given between 9 am and 3 pm:	Yes: ______________	No: ______________
Vulnerable Adult Policy reviewed and signed by Client and Guardian:	Yes: ______________	No: ______________
Client Rights reviewed and signed by Client and Guardian:	Yes: ______________	No: ______________
Consumer Bill of Rights reviewed and signed by Client and Guardian:	Yes: ______________	No: ______________
Reviewed and signed Notice of Privacy and Practice form (form 23005):	Yes: ______________	No: ______________
Copy of Minnesota Provider Notice of Privacy Practices given to Guardian:	Yes: ______________	No: ______________

Responsible Coordinator: ______________________