Arc
MORRIS

INTAKE APPLICATION FORM

Consumer Name: _____ Date of Intake: _____

Address: _____ Date of Birth: _____

_____ Social Security. #:_____

Phone #: _____ Gender: Male____ Female____

Municipality of Residence (where you pay your taxes) _____

Type of Living Arrangement: _____

Have you or a family member received services from Arc/Morris in the past? Y N

If yes, please describe _____

Guardianship Status: _____

Name of Guardian: _____ Relationship: _____

Address: _____ Phone #: _____

_____

Emergency Contact Name and Phone #: _____

Relationship: _____

U.S. Citizen: Yes ____ No ____ If no, current immigration status/resident number _____

CASE MANAGEMENT INFORMATION:

Is consumer receiving services from:	Contact/Case Manager	Phone
_____Division of Youth & Family Services	_____	_____
_____Special Child Health Services	_____	_____
_____School District Child Study Team	_____	_____
_____NJ Division of Dev. Disabilities (DDD)	_____	_____

MIS # _____

_____Other: _____

MEDICAL PSYCHO-SOCIAL INFORMATION

Primary Diagnosis: _____

Secondary Diagnosis: _____

Tertiary Diagnosis: _____

Other: _____

Cognitive Functioning Level: _____

MEDICAL INFORMATION:

Primary Medical Diagnosis: _____

_____

Immunizations:

Date of Last Tetanus Shot: _____ Others? _____

DIETARY INFORMATION: Prescribed for: _____

_____

Primary Physician: _____ Date of Last Exam: _____

Address: _____ Phone: _____

_____

Medicaid #: _____ Medicare #: _____

Other Insurance Name: _____ Policy #: _____

CONSUMER MEDICAL HISTORY: (Previous Hospitalizations, Major/Minor Conditions)

_____

_____

FAMILY HISTORY:			
	Diabetes	Y _____	N _____
	Heart Disease	Y _____	N _____
	Blood Pressure Issues	Y _____	N _____
	Seizures	Y _____	N _____
	Hepatitis	Y _____	N _____
	Other (please explain)	Y _____	N _____

HOSPITALIZATIONS:

_____

_____

OTHER PHYSICIANS:

Neurologist: _____ Phone: _____ Dental: _____ Phone: _____

Eye: _____ Phone: _____ Psych: _____ Phone: _____

Gyn: _____ Phone: _____ Other: _____ Phone: _____

Other: _____ Phone: _____ Other: _____ Phone: _____

PSYCHIATRIC INFORMATION:

Diagnosis: _____

_____

History: _____

_____

Receiving Counseling/Therapies? _____

_____

Hospitalizations: _____

_____

_____

Allergies: Please List _____

_____

Current Medications as of: _____

Medication Name	Purpose	Prescribed By	Date Prescribed

Previous Medications Used; Reason for Discontinuation:

_____

_____

_____

CONSUMER'S WORK/DAY PROGRAM INFORMATION:

Place: _____ Contact: _____

Address: _____ Phone: _____

Hours: _____Transport: _____

First Date of Employment/Day Program: _____

Permission to use Name for purpose of communicating activities of The Arc/Morris Chapter?

Y _____ N_____

Photo Release: Y _____ N _____

Cognitive/Behavioral Information:

_____

_____

_____

_____

_____

PRIMARY MODE OF COMMUNICATION:

CAN IDENTIFY NEEDS/FEELINGS: Y_____N _____

☐ Verbal ☐ Language Board ☐ Gesture ☐ Augmentative Device ☐ Sign

LEVEL OF SUPERVISION- AS DOCUMENTED IN THE IHP/IDT:

_____

_____

_____

Assistance Needed?	Independent	Reminders	Verbal Prompts	Physical Assistance	Not Able
FEED					
DRESS					
TOILET					
BATHE					

MOBILITY/RESTRICTIONS/INCLUDE LIMIATIONS TO ACTIVITIES:

☐ Wheelchair ☐ Walker ☐ Crutches/Cane ☐ Leg Braces

Special Aides:

☐ Glasses ☐ Hearing Aid ☐ Dentures ☐ Helmet

☐ Orthopedic Shoes ☐ Other ☐ Other ☐ None

Other Considerations:

Fears _____ PRN Needed

_____ for Hospitalization_____

Tolerance_____ Idiosyncrasies _____

to Pain _____

Unusual _____

Behavior _____

BEHAVIOR PLAN/RECOMMENDATIONS:

Specific Target Behavior: _____

_____

Describe Method: _____

_____

_____

_____

Specific Behavioral/Crisis Interventions (antecedents, successful techniques)

_____

_____

_____