Individual Demographic Form (IDF)

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Entered By: _____

Date: _____ Time _____ AM / PM

Photo 1: □ Attached Photo 1 Date: _____

Title: □ Mr □ Miss □ Mrs □ Ms □ Mx Gender: □ Male □ Female □ Unknown

First Name:* _____ Last Name:* _____

Middle Name: _____ Suffix: _____

Birth Date: _____ Goes By: _____

SSN: _____ Medicaid Number: _____

Email: _____ Phone Number: _____

Race:

□ American Indian/Alaskan Native □ Asian □ Asian Indian □ Black/African American □ Chinese □ Declined □ Filipino □ Guamanian or Chamorro □ Japanese □ Korean □ Multiracial □ Native Hawaiian/Other Pacific Islander □ Samoan □ Undetermined □ Unknown □ Vietnamese □ White □ Other

Ethnicity / Hispanic Origin:

□ Bengali □ Central American □ Chakma □ Chinese □ Cuban □ Hispanic □ Indian □ Magar □ Malays □ Marma □ Mexican □ Moor □ Newar □ Not Hispanic or Latino □ Other Spanish Origin □ Puerto Rican □ Sinhalese □ South American □ Tamang □ Tamil □ Tharu □ Unable to Determine

Tribe: _____

Class Membership: _____

Residential Address:

Residential Program/Site Address: _____

Attention or in care of: _____

Street 1: _____ Street 2: _____

City: _____ State: _____

Zip Code: _____ Country: _____

Primary Phone: _____ Secondary Phone: _____

Additional Phone: _____

Residential County State: _____ Residential County: _____

Service County State: _____ Service County: _____

Mailing Address:

□ Same as Residential Address

Attention or in care of: _____

Street 1: _____ Street 2: _____

City: _____ State: _____

Zip Code: _____ Country: _____

Primary Phone: _____ Secondary Phone: _____

Additional Phone: _____

Address List

Name	Street 1	Street 2	City	State	Zip Code	Country	Primary Phone	Secondary Phone

Advance Directives

Advance Directive	□ Yes	□ No	Date: _____	□ Attachment
DNR Order	□ Yes	□ No	Date: _____	□ Attachment
Durable Power of Attorney for Health Care	□ Yes	□ No	Date: _____	□ Attachment
Living Will	□ Yes	□ No	Date: _____	□ Attachment
Preferred Intervention for Known Condition	□ Yes	□ No	Date: _____	□ Attachment

Comments: _____

_____

_____

_____

Allergy Profile

Allergy Status □ No Known Allergy □ Known Allergy □ Unknown Allergy
Drug Allergy Status □ No Known Allergy □ Known Allergy □ Unknown Allergy

Active Allergies:

Allergy	Coding System	Code	Description	Type	Severity	Identification Date	Reaction	Diagnosed By

Comment: _____

_____

_____

_____

Assessment List

Assessment Type	Assessment Score	Assessment Date	Comments	Attachment

Case Status

Case Status

□ Active □ Application Withdrawn □ Awaiting Discharge □ Closed - Deceased □ Closed - Individual Choice
□ Closed - Moved Out of State □ Closed - No Response □ DD Eligible/Waiver Ineligible □ Home Health Only
□ Inactive □ Leave of Absence □ Long Term Hospitalization □ Not Eligible □ PASRR

Start Date: _____ End Date: _____

Consent List

Consent Name	Consent Type	Consent Status	Effective From	Effective To	Consent Obtained Date/Time	Consent Document	Comments	Consenter

Contact List

Contact Name	Agency	Relationship to Individual	Emergency Contact?	Mailing Contact?	Comments	Is Guardian?	Address	Mailing Address

Custom Fields

1.
2.
3.
4.
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10.
11.
12.
13.
14.
15.

Health Profile

Height: ____ Feet ____ Inch

Weight Range: From _____ To _____ lbs

Vital Signs Normal Ranges:

Temperature: From _____ To _____ F

Respiration: From _____ To _____ BPM

Pulse: From _____ To _____ BPM

Blood Pressure Systolic: From _____ To _____ mmHg

Oxygen Saturation: From _____ To _____ %

Blood Pressure Diastolic: From _____ To _____ mmHg

Diagnosis List

Active Diagnosis

Diagnosis Coding Type	Diagnosis Code	Description	Diagnosis Date	Diagnosed By	Entered By	Is Primary Diagnosis?

Individual Details

Photo 2: □ Attached Photo 2 Date: _____

Hair Color: □ Bald □ Black □ Blonde □ Brown □ Brown-dark □ Brown-light □ Brunette □ Gray □ Red □ White

□ Other: _____

Eye Color: □ Black □ Blue □ Brown □ Dichromatic □ Gray □ Green □ Hazel □ Opaque □ Other: _____

Interpreter Needed: □ Spoken □ Written □ Written and Spoken □ No □ Unknown

Primary Oral Language:

□ American Sign Language □ Arabic □ Armenian □ Bengali □ Bhojpuri □ Bosnian □ Braille □ Chinese (Mandarin) □ Cambodian □ Creole □ Danish □ Does not Read or Write □ English □ French □ German □ Hebrew □ Hungarian □ Italian □ Japanese □ Karen □ Karenni □ Korean □ Kurdish □ Laotian □ Latvian □ Limbu □ Maithili □ Marshallese □ Native American □ Nepal Bhasa (Newari) □ Nepali □ Norwegian □ Polish □ Portuguese □ Romani □ Romanian □ Russian □ Serbo-Croatian □ Sign Language-Seell □ Sinhalese □ Sioux □ Somali □ Spanish □ Sudanese □ Swedish □ Tagalong □ Tamil □ Tharu □ Ukranian □ Vietnamese □ Other: _____

Primary Written Language:

□ American Sign Language □ Arabic □ Armenian □ Bengali □ Bhojpuri □ Bosnian □ Braille □ Chinese (Mandarin) □ Cambodian □ Creole □ Danish □ Does not Read or Write □ English □ French □ German □ Hebrew □ Hungarian □ Italian □ Japanese □ Karen □ Karenni □ Korean □ Kurdish □ Laotian □ Latvian □ Limbu □ Maithili □ Marshallese □ Native American □ Nepal Bhasa (Newari) □ Nepali □ Norwegian □ Polish □ Portuguese □ Romani □ Romanian □ Russian □ Serbo-Croatian □ Sign Language-Seell □ Sinhalese □ Sioux □ Somali □ Spanish □ Sudanese □ Swedish □ Tagalong □ Tamil □ Tharu □ Ukranian □ Vietnamese □ Other: _____

Religion:

□ AME □ Baptist □ Buddhist □ Catholic □ Christian □ Church of Latter Day Saints □ Congregational □ Eastern Orthodox □ Episcopal □ Greek Orthodox □ Hindu □ Jehovah's Witness □ Jewish □ Lutheran □ Lutheran - ELCA □ Lutheran - ELS □ Lutheran - LCMS □ Lutheran - Other □ Lutheran - WELS □ Methodist □ Mormon □ Muslim □ Nazarene □ Non-Denominational □ None □ Pentecostal □ Presbyterian □ Protestant □ Seventh Day Adventist □ Spiritualist □ Unitarian □ Other: _____

Citizenship: □ Bangladeshi □ Canada □ Indian □ Indonesian □ Malaysian □ Nepali □ Singaporean □ Sri Lankan □ Thai □ USA □ Other: _____

Citizenship Status: □ Alien □ Asylee □ Cuban-Haitian □ Illegal Alien □ Ineligible Alien □ Military/Fam Non-Citizen □ Refugee UNACOM Minor □ Refugee □ Sponsored Alien □ U.S. Citizen □ Victims/Trafficking

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

Marital Status Date: _____

Admission Date: _____

Discharge Date: _____

Death Date: _____

Individual's Time Zone*:

□ America/Puerto_Rico □ Asia/Bangkok □ Asia/Colombo □ Asia/Dhaka □ Asia/Jakarta □ Asia/Kathmandu □ Asia/Kolkata □ Asia/Kuala_Lumpur □ Asia/Manila □ Asia/Phnom_Penh □ Asia/Singapore □ Asia/Thimphu □ Pacific/Guam □ US/Alaska □ US/Aleutian □ US/Arizona □ US/Central □ US/East-Indiana □ US/Eastern □ US/Hawaii □ US/Indiana-Starke □ US/Michigan □ US/Mountain □ US/Pacific □ US/Pacific-New □ US/Samoa

Living Arrangement:

□ 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 □ ETLA – Emergency Transition Living Arrangement □ Family Home □ Forensic Unit □ Foster Care □ Group Home □ Halfway House □ Homeless Shelter □ Hospital - Acute Hospital Care □ Hospital - Psychiatric □ Independent Living □ Institution - Psychiatric Care - IMD □ Intermediate Care Facility for ID/DD □ IRA □ Licensed Center For Developmentally Disabled □ Licensed Community Care □ Licensed DD Group Home □ Licensed Domicilary 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 □ Out of State Placement □ PCS Home □ Public Housing □ Rite at Home □ Room Only □ Shared Living Arrangement □ Supervised Living Arrangement □ Supported Living

Birth Place

Street 1: _____ Street 2: _____

City: _____ State: _____

Zip Code: _____ Country: _____

Characteristics: _____

_____

_____

_____

_____

Guardian of Self: □ Yes □ No □ Unknown

ID Numbers

ID Type: _____ ID Number: _____

Additional ID Type: _____ Additional ID Number: _____

Other ID Types: Other ID Numbers:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical Information

Developmental Disability: □ Autism □ Cerebral Palsy □ Epilepsy □ Neurological Impairment □ Other

Intellectual Disability: □ Mild □ Moderate □ Profound □ Severe □ Unspecified

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

Primary Care Physician: _____

Other Medical Information: _____

_____

_____

_____

_____

Emergency Orders: _____

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_____

_____

Adaptive Equipment: _____

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Behavior

Behavior Management: _____

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_____

Guidelines

Dietary Guidelines: _____

_____

_____

_____

_____

Eating Guidelines: _____

_____

_____

_____

_____

Communication Modality: □ Communication Device □ Non-Verbal □ Partially Verbal □ Sign □ Verbal □ Other

Communication Modality Other: _____

_____

_____

_____

_____

Communication Comments: _____

_____

_____

_____

_____

Mobility: □ Uses a cane □ Uses a white cane □ Uses Crutches □ Uses walker □ Walks on own
□ Walks with assistance □ Walks with Gait Belt □ Wheelchair □ Wheelchair - Electric □ Wheelchair - Standing
□ Other: _____

Mobility Comments: _____

_____

_____

_____

_____

Supervision: □ 1:1 □ Arm's Length □ Assistance for everything □ Assistance for everything but eating
□ Assistance for personal care □ Determined by Family □ Independent □ Line of Sight □ Never unattended
□ No supervision □ Range of Scan □ Supervision for personal care □ Visual Scan □ Other: _____

Supervision Comments: _____

_____

_____

_____

_____

Food Texture: □ 1" Pieces Cut to Size □ 1/2" Pieces Cut to Size □ 1/4" Pieces Cut to Size □ Food consistency altered-Chopped □ Food consistency altered-Uses Thickener □ Ground □ Nothing by mouth-NPO □ Pureed □ Whole or Normal Consistency

Liquid Consistency: □ Honey □ Nectar □ Nothing by mouth-NPO □ Pudding □ Regular □ Thin

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

Bathing Status: □ Independent □ Independent with Devices □ Requires Support to Bath/Shower

Mealtime Status: □ Eats Independently (with or without adaptive equipment) □ Requires Physical Assistance/Equipment □ Requires Positioning Equipment □ Requires Support to Eat

Referral Source: _____

_____

_____

_____

_____

□ 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.

Insurance

Medicare

Medicare Section: □ A □ B □ A and B

Medicare Number: _____ Medicare Effective Date: _____

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: _____

Oversight

Oversight Name	Oversight Type	Oversight ID

Pending Admission Notes

Notes	Entered By	Entered Date

Program Enrollments

Program Name	Site Name	Enrollment Date	Discharge Date

Shared Contact List

Title	Name	Organization	Type	Specialty	NPI Number	Primary Address	Mailing Address

Team Members

Type	Name	Relationship with the Individual	Legal Decision Maker?	Is Guardian?

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