Safe Transitions

Application for Services

Person Served Information-ILS/IHS

Person Information	**Date form was completed:**	
Full name:	Admission Date to Safe Transitions:	
Date of Birth:	Gender:	Social security number:
House Name & Address:	Phone number:	Cell number:
Marital Status: Race:	County of Residence:	Commitment Dates:
Price-Shephard Dates:	Jarvis Dates:	Probation Dates: Contact Info:
Height: Weight:	Eye Color: Hair Color:	Outstanding Warrants: __No__Yes Court Ordered Child Support: __No__Yes
Date of CSSP (attach copy): **If no CSSP, date Goal Area List completed:** Date of Diagnostic Assessment/Psychiatric Evaluation (request copy): Need Wheelchair Accessible Vehicle? __No__Yes		
County, State, Country of birth:		

Legal status

□ responsible for self □ under guardianship □ Minor □ under commitment □ under Jarvis □ Price-Sheppard

Insurance Information

Primary insurance number:	Medical Assistance number:
Medicare number: Part A Start Date: Part B Start Date:	Prescription/Other insurance information:
Waiver Type: ☐ CADI ☐ DD ☐ BI ☐ ILS ☐ IHS with training ☐ IHS without training ☐ IHS with family training ☐ ARMHS Provider:_____ **Number of hours requested for ILS/Week_____** **Requested Service Days/Times:** ☐ Sun; Times:_____ ☐ Mon; Times:_____ ☐ Tue; Times:_____ ☐ Wed; Times:_____ ☐ Thur; Times:_____ ☐ Fri; Times:_____ ☐ Sat; Times:_____ **PETS IN THE HOME:**	

Legal representative contact information-Coordination between: MHW, HS, PC, PD with Legal Rep

Full name: Relationship:	Email:
Address:	Fax number:
Office number:	Cell number:

County/MH Case Manager contact information-Coordination between: PC, PD with CM

Full name:	Email:

Address:	Fax number:
Office number:	Cell number:

Waiver/CADI Case Manager contact information-Coordination between PC, PD with CM

Full name:	Email:
Address:	Fax number:
Office number:	Cell number:

Financial Manager contact information

County of Financial Responsibility contact information

County & contact name:	County Name:
Address:	Address:
Email:	Email:
Office number: Fax number:	Office number: Fax number:

Coordination between PC, PD with Financial Manager/Worker or County of Financial Responsibility

Representative Payee contact information-Coordination between PC, PD with Rep Payee

Full name: Relationship:	Email:
Address:	Fax number:
Office number:	Cell number:

Primary Diagnosis and Code:
Other Diagnoses:
Type of Funding (enter amounts) RSDI: SSI: Other Income (Type & Amount):

Employment Information-Coordination between MHW, HS, PC with Employment

Employer: Start Date: Stop Date:
Phone number:
Address: Contact Name:
Supported Employment (State/County Funded Employment): _____Yes _____No

Discharge Information

Emergency Discharge: _____Yes _____No Discharge Date:
Forwarding Address:
Phone: Contact Person: ROI?

Update form as changes occur and each January and fax first 2 pages to the Finance Department (218) 389-9851

Primary emergency contact information-Coordination between MHW, HS, PC, PD and Emergency Contact

Full name:	Email:
Address:	Fax number:
Office number:	Cell number:

Important People to the Person-Coordination between MHW, HS, PC, PD and Important People to the Person

Full name:	Email:
Address:	Fax number:
Office number:	Cell number:

Full name:	Email:
Address:	Fax number:
Office number:	Cell number:

Health care provider contact information-Coordination between MHW, HS, PC, PD and Health care providers

Primary physician name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

Psychiatric care provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:
Optometric care provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

Neurology care provider name:	
Clinic Name: Address:	
Phone number:	Fax number:

Therapy provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

Dental provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

Other provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

Other provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

This program is responsible for assisting this person in setting up medical appointments: **__Yes __ No** Advance Directive? **__Yes __ No** DNR/DNI **__Yes __ No** Request copy, if applicable.

Individual Abuse Prevention Plan (IAPP)

A. Sexual abuse Is the person susceptible to abuse in this area? **__ No __Yes**

Lack of understanding of sexuality **__ No __Yes, describe:**

Likely to seek or cooperate in an abusive situation **__ No __Yes, describe:**

Inability to be assertive **__ No __Yes, describe:**

Other **__ No __Yes, describe:**

B. Physical Abuse Is the person susceptible to abuse in this area? **__ No __Yes**

Inability to identify potentially dangerous situations **__ No __Yes, describe:**

Lack of community orientation skills **__ No __Yes, describe:**

Inappropriate interactions with others **__ No __Yes, describe:**

Inability to deal with verbally/physically aggressive persons **__ No __Yes, describe:**

Verbally/physically abusive to others **__ No __Yes, describe:**

"Victim" history exists **__ No __Yes, describe:**

Other **__ No __Yes, describe:**

C. Self-Abuse Is the person susceptible to abuse in this area? **__ No __Yes**

Dresses inappropriately **__ No __Yes, describe:**

Refuses to eat **__ No __Yes, describe:**

Inability to care for self-help needs **__ No __Yes, describe:**

Lack of self-preservation skills (ignores personal safety) **__ No __Yes, describe:**

Engages in self-injurious behaviors **__ No __Yes, describe:**

Neglects or refuses to take medications **__ No __Yes, describe:**

Other **__ No __Yes, describe:**

D. Financial Exploitation Is the person susceptible in this area? **__ No __Yes**

Inability to handle financial matters **__ No __Yes, describe:**

Other **__ No __Yes, describe:**

E. Is the program aware of this person committing a violent crime or act of physical aggression toward others?

__ No __Yes, describe:

Hopes and Dreams:

What are your hopes and dreams for the future? What are some of the most important things you want to have in your life?

If you could change anything in your life right now what would it be?

Strengths and Interests

Strengths: My best qualities, things I am most proud of, people say they like…, times I am at most peace, things that help me make it through the day when I am down are:

Interests: Things I enjoy at home or in the community, am interested in or would like to learn about, like to show other people how to do, used to feel good about before you began to experience symptoms, care a lot about:

Things that are Important to You

What do you want to maintain, accomplish, or want help with now?

Health information

Medical History (Do you have any serious or persistent medical conditions we should be aware of (for example heart or respiratory problems, diabetes, seizures, etc.)

Do you have any communicable diseases?

Do you take your medications as ordered? *Have you ever said you took your meds when you really did not take them?

Staff administered injectables?

Assistive Devices (cane/walker/splints/ braces/glasses/hearing aids/orthotics/shower chair, etc)

Special dietary needs:
Allergies:

Refusal to admit a person is based on an evaluation of the person' assessed needs and the license holder's lack of capacity to meet the needs of the person.

I have reviewed this application for services and they are true and accurate to the best of my knowledge.

Name	Signature	Title	Date
		Person	
		Legal Representative	
		Case Manager	
		Cadi/Waiver Case Manager	

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For office use only
This person is accepted for services: ____ Yes ____ No
Intake Date: _____

This person is declined for services: ____ Yes ____ No
Date: _____
Explain: