

Greatest Risks: (check all that apply)

Risk of Loss of Placement ____, Breaks the Law ____, Eats Non-Nutritive Substances ____, Elopes ____,

Inappropriate Sexual Behavior ____, Injurious to Self ____, Physical Aggression ____, Property Destruction ____,

Verbal/Gestural Aggression ____, OTHER _____

COMMENTS: _____

DIAGNOSIS INFORMATION:

IDD level: (please check)

Borderline ____, Mild ____, Moderate ____, Severe ____, Profound ____, Related Condition _____

ID/DD Diagnosis YES ____ NO ____

Allergies: (list all that apply) _____

Level of ADL's : Independent ____, Needs Assistance ____, Needs Prompts _____

Communication level: Limited ____, Not Verbal ____, Verbal ____

Psychiatric Diagnosis: _____

Medical Diagnosis: _____

Misc. Info: YES or NO (please check the following)

Client had Previous Psychiatric Hospitalization

Has a Behavior Support Plan

Has a Positive Support Transition Plan

Is taking Psychotropic Medication

Has an Individual Abuse Prevention Plan

LIST ALL CURRENT MEDICATIONS: _____

SUPPORT TEAM CONTACT INFORMATION:

Guardian:

Name _____

Relationship _____

Day Phone _____

Evening Phone _____

Mobile Phone _____

Email address _____

Street Address _____

City _____

State _____

Zip Code _____

Guardians Legal status: Self ____ - A Private Guardian ____ - State Appointed ____

Additional contacts/ info/comments: _____

Residential Supports:

Type of Residence: (check one) Family Home____, Group Home____, Foster Home____, ICF____, Own apartment/home____

Support Type: _____

Provider Company Name: _____

Primary Contact Person: _____/title _____ Phone # _____

FAX: _____

Email _____

Secondary Contact Person: _____/title _____ Phone# _____

Email _____

COMMENTS: _____

CASE MANAGER:

County of Financial Responsibility _____

Name: _____

Address: _____

City _____

State _____

Zip _____

PHONE _____ FAX _____

EMAIL _____

EDUCATION or Day Supports:

School or Program name _____
Contact Name _____
Phone number _____
Mobile Phone _____
Email Address _____
Street Address _____
City _____
State _____
ZIP _____
Additional info _____

IF THE CLIENT IS CURRENTLY AT THE HOSPITAL:

Name of Hospital: _____
Primary Hospital Contact Person's name _____/title
Phone number _____
Admission date: _____

Additional info and/or Additional contacts at the hospital (please include name/title/phone number:

After this form is completed, please fax it along with the client's Individual Abuse Prevention Plan - or Health and Safety Plan, ISP - or similar case manager documentation to 612-869-6743 - Attention to: INTAKE

MCCP will process this intake and assign it to a Behavior Analyst who will make initial contact with team members.