Demographic Form

Last Name:
First Name:
DOB:
Medicaid#:
SSN:

To be completed by the Care Coordinator.

See Instructions Below.

Plan of Care Start Date: **Date Demographic Form Submitted:**

1) At the time of the last ICAP, was the client living in, or within 3 months of discharge from, an institution, correctional facility, or long-term care facility? ☐ Yes ☐ No
Name of Facility:
Discharge Date:

2) Primary Diagnosis:

Secondary Diagnosis:

3) Have there been significant changes in the client's behavior or health in the last year? ☐ Yes ☐ No
Specify and attach appropriate supporting documentation:

☐ Letter attached from a qualified professional.*

Primary Physician Information
Last Name:
First Name:
Physical Address:
Fax Number:
Phone Number:

Care Coordinator Information (individual completing this form)
Last Name:
First Name:
Agency:
Phone:
Email:

Instructions:

Each of the fill-in boxes within this form must be completed. Enter "n/a" if not applicable.
1. At the time of last ICAP, was the client living in, or within 3 months of discharge from, an institution, correctional facility or long-term care facility? If yes, facility name and discharge date. Answer yes if the person was in a skilled nursing facility, rehabilitation center, jail, halfway house, or other correctional facility, or an out-of-state treatment facility. Group homes or assisted living facilities are not institutions. Be sure to include the discharge date to the best of your knowledge. If you are not sure if the client's placement counts, please list it and briefly describe its purpose.

Fax completed forms and documentation to appropriate DSDS Regional Office:
Southcentral (907)269-3639 Northern (907)451-5046 Southeast (907)465-2677

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2. Primary Diagnosis and Secondary Diagnoses? Has the client received a new primary diagnosis? Has the client been diagnosed with any new health problems, mental health issues, or other problems that might affect his/her functional abilities?

3. Have there been significant changes in the client's behavior or health in the last year? If yes, concisely explain, and attach appropriate supporting documentation.
Outline significant changes that would influence the qualifying diagnosis, or change the level of services required or provided for the client.

** Letter attached from a qualified professional*. A letter written by a qualified professional, as defined in the ICF/MR LOC Guidelines, January 2006 Update, and written within the last 12-month period certifying the client continues to meet the diagnostic criteria for their qualifying diagnosis. Letter must be on office letterhead, and be signed and dated.

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