

Individual Data

Name of Individual		CARE ID	Date of Birth	Permanency Plan Required <input type="checkbox"/> Yes <input type="checkbox"/> No	
Local Case No.			Social Security No.	ICAP Date/LON	
Medicaid No.	Medicaid Type	Medicare No.	Medicare Type		
If not currently receiving Medicaid, has a Medicaid application been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No				Medicaid Application Date	
Private Insurance			Emergency Contact Name and Telephone No.		
Primary Correspondent (If different from Emergency Contact)			Telephone No.	Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No	Guardianship Current <input type="checkbox"/> Yes <input type="checkbox"/> No
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		Language <input type="checkbox"/> English <input type="checkbox"/> Vietnamese <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	Reads English <input type="checkbox"/> Yes <input type="checkbox"/> No	Understands English <input type="checkbox"/> Yes <input type="checkbox"/> No
Race/Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other:	Housing Assistance <input type="checkbox"/> Section 8 <input type="checkbox"/> Shelter Plus <input type="checkbox"/> Other subsidized <input type="checkbox"/> On waiting list <input type="checkbox"/> N/A		Living Arrangement prior to enrollment <input type="checkbox"/> Own Home <input type="checkbox"/> State Facility <input type="checkbox"/> Family Home <input type="checkbox"/> Foster/Companion Care <input type="checkbox"/> ICF/IID <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other, describe:		
Legal Status <input type="checkbox"/> Legal Adult <input type="checkbox"/> Minor <input type="checkbox"/> Conservator <input type="checkbox"/> Guardianship of Person <input type="checkbox"/> Guardianship of Estate <input type="checkbox"/> Guardianship of Both	Communication <input type="checkbox"/> Uses words <input type="checkbox"/> Uses gestures <input type="checkbox"/> Does not use words <input type="checkbox"/> Sign language <input type="checkbox"/> Communication devices <input type="checkbox"/> Other, describe:		Ambulation <input type="checkbox"/> No assistance required <input type="checkbox"/> Somewhat limited <input type="checkbox"/> Total assistance required If assistance is required, describe:		Community/Home Safety <input type="checkbox"/> Needs total assistance <input type="checkbox"/> Needs some assistance <input type="checkbox"/> Requires physical guidance <input type="checkbox"/> Totally independent <input type="checkbox"/> Requires verbal prompts <input type="checkbox"/> Unknown
Check any needs that apply: <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Behavioral needs <input type="checkbox"/> Eating assistance <input type="checkbox"/> Assistance with toileting <input type="checkbox"/> Visually impaired <input type="checkbox"/> Medical needs <input type="checkbox"/> Other, describe:			Check adaptive aids that apply: <input type="checkbox"/> Communication aids <input type="checkbox"/> Wheelchair/scooter <input type="checkbox"/> Walker/cane <input type="checkbox"/> Bathroom aids <input type="checkbox"/> Prosthetics <input type="checkbox"/> Eyeglasses <input type="checkbox"/> Vehicle lifts <input type="checkbox"/> Hearing aids <input type="checkbox"/> Other, describe:		
If any box is checked above, additional information may need to be described in the Person-Directed Plan.					
Completed or updated on _____.					
Date					