RESIDENT INFORMATION

Date of Placement _____
Date Placement Ends _____

Name (last, first, middle) _____

Birthdate _____ Age _____

	NAME	PHONE NUMBER
Social Worker – Work	_____	_____
Home (optional)	_____	_____
Social Worker's Supervisor	_____	_____
Financial Worker	_____	_____
Financial Worker's Supervisor	_____	_____
Social Security Office	_____	_____
Resident's Social Security No.	___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Psychologist/Psychiatrist	_____	_____
Physician	_____	_____
Dentist	_____	_____
Outpatient Clinic	_____	_____
Religion/Name of Church (optional)	_____	_____

INFORM IN EMERGENCY:

Name _____ Name _____
Address _____ Address _____
Phone Number _____ Phone Number _____
If unavailable, call EMERGENCY SOCIAL SERVICE (evenings/weekends) at 320-632-9233.

Day Program/Employment	Contact Person	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medical/Physical Status

Date of Last Physical Exam (month/year) _____
Date of Last Dental Exam (month/year) _____
Date of Last Eye Exam (month/year) _____
Special Diet/Allergies _____

Type Medical Insurance/Policy Number (optional): MA _____
Medicare _____ Other _____
Type Life Insurance/Policy Number (optional): _____
Prepaid Burial Plan (optional): Amount $ _____
Funeral Home _____ Cemetery Lot _____

Current Medications

Name	Dosage	Date Started	Presented By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ Self Administered ☐ To Be Supervised

Adverse Effects from Previous Drugs (describe) _____

Summary of Problem (diagnosis): _____

Other Problems: (Check all that apply)

☐ Sight ☐ Hearing ☐ Mental Illness ☐ Chronic Health Problem

☐ Speech ☐ Physically Handicapped ☐ Mentally Retarded ☐ Other _____

Comments: _____

Chemical Use Pattern _____

Drug of Choice _____

Hospitalizations (within one year prior to placement)

___ ___ ___ Number of Days in Psychiatric Treatment Hospitals

___ ___ ___ Number of Days in Other Hospitals

___ ___ ___ Number of Admissions to State Hospitals

___ ___ ___ Number of Admissions to Other Hospitals

Comments _____

_____

Probate Court Status _____ Continuance/Expiration Date_____

Comments_____

Family Members Name	Relationship	Address	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List People Important to Resident

Name	Relationship	Address	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RELEASE OF INFORMATION – *The above facts are intended to provide information for Adult Foster Care. I hereby authorize the release of all information on this form to:*

(Name of Provider) _____. I further authorize:

(Name) _____ (Name) _____

to discuss this information with the provider as it relates to my placement in Adult Foster Care. THIS RELEASE SHALL REMAIN IN EFFECT FOR ONE YEAR.

Name of Resident_____ Date _____