

Resident Placement and Demographic Information

Resident Information

| Resident Demographic Information | |
|-------------------------------------|-----------------------|
| Name: | Prefers to be called: |
| Date of birth: | Age at admission: |
| Social Security Number: | Cell #: |
| Guardian Name: | Phone #: |
| Guardian Email: | |
| Rep Payee (or POA) Name: | Phone #: |
| Other Rep Email: | |
| Emergency Contact Name: | Phone #: |
| Email: | |
| Primary Health Care Facility: | |
| Primary Doctor/Provider Name: | Phone #: |
| Dental Facility: | |
| Dentist Name: | Phone #: |
| Specialty Provider Facility: | |
| Provider Name/Title: | Phone #: |
| Placing Worker: | PW Phone #: |
| Placing Worker Email: | |
| Secondary Placing Worker: | PW Phone #: |
| Secondary PW Email: | |
| County of Financial Responsibility: | Waiver/Funding Type: |
| Insurance Plan: | Policy #: |

Admission/Discharge Information

| Placement Information – maintain records for 5 years after discharge | |
|---|---|
| Date of Placement: | Date of Discharge: |
| Place/address prior to admission: | |
| Reason for admission/primary diagnosis: | |
| Date RLS notified of placement: | Date RLS notified of discharge: |
| Service Termination Date (if applicable): | (30 days min. for EW, 60 for all other waivers) |
| Place/address of discharge: | |
| Reason for discharge: | |
| Note: If the discharge is due to death, include the following information in your notification to your RLS: Resident Name, DOB, date of death, cause of death, and any other pertinent information | |

Individual Record

| Item | Rule | Date completed/obtained |
|---|---|-------------------------|
| Preplacement Items | | |
| Assessment to determine need for adult foster care | 9555.5605 Subp. 1 | |
| Preplacement visit | 9555.5605 Subp. 6 | |
| Admission Items | | |
| Consent to Share a Bedroom | 9555.6205 Subp. 4 | |
| Demographic Information | 9555.6245, Subp. 2 | |
| Individual Abuse Prevention Plan | 9555.6245, Subp. 1 | |
| Individual Resident Placement Agreement | 9555.5705 Subp. 2 and 9555.6245 Subp. 8 | |
| Individual Service Plan | 9555.6245 Subp. 7 | |
| Medical Information and Medication Permissions | 9555.6245 Subp. 3 and 9555.6225 Subp. 8 | |
| Mobility Access Assessment | 9555.5605 Subp. 2 and 9555.6245 Subp. 9 | |
| Physical Examination of Resident with communicable disease status and plan if required (within 30 days prior or 3 days after placement) | 9555.6225 Subp. 3 and 4605.7000 to 4605.7800 | |
| Notice of Residential Placement – completed by case manager | Form DHS 7418 | |
| Notification of home pets (if applicable) | 9555.6225, Subp. 7 | |
| Cash resource permissions (if provider will assist) | 9555.6245 Subp. 4 | |
| Admission Items within 24 hours | | |
| Complaint and Grievance Procedures, Maltreatment reporting policy, and Vulnerable Adults Act Summary | 245A.11 Subd. 10 (a) and 245A.65, Subd. 1(c) | |
| Drug and Alcohol Policy | 245A.04, Subd. 14 (b) (3) | |
| Program Abuse Prevention Plan | 9555.6235 C & 626.557, Subd. 14 & 245A.65, Subd. 2 | |
| Resident Rights, HIPAA, and Data Practices (<i>including releases of information</i>) | 245A.11 Subd. 7 (b) and 10 (a) and 9555.6245, Subp. 1 | |
| Placement Review | | |
| Placement Review (within 30 days of placement) | 9555.5705 Subp. 2 | |

Release of Information and Signature of Receipt

I hereby authorize the release of the information contained in this form to:

Provider Name

This release shall remain in effect until I discharge or revoke my release in writing.

I acknowledge I have received orientation to, and completion of all items listed in the Individual Record section of this form.

Resident Signature

Date

Guardian Signature

Date