DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

# DDA Mobile Diversion Services Referral and Intake Information

| CLIENT'S FULL NAME | | DATE OF BIRTH | ADSA NUMBER |
|---|---|---|---|
| CLIENT'S CURRENT PHYSICAL ADDRESS | | | |
| DDA CASE MANAGER | | DDA CM TELEPHONE NUMBER | |
| RESIDENTIAL AGENCY PROVIDER, IF APPLICABLE | | PROVIDER TELEPHONE NUMBER | |
| FAMILY / LEGAL REPRESENTATIVE (INCLUDE GUARDIANSHIP ORDER, IF APPLICABLE) | | REPRESENTATIVE TELEPHONE NUMBER | |
| PRIMARY CAREGIVER | TELEPHONE NUMBER | EMAIL | |

Current living situation

Communication style (nonverbal / verbal, primary language, preferred modes):

Diagnosis:

Briefly describe why this person is being referred. List current symptoms / behaviors of concern (define and state frequency and severity of each symptom/behavior).

Describe all known medical or physical treatment support needs:

Describe all known behavioral treatment or support needs::

Describe all known allergies:

History of substance use:

History of property destruction:

Legal History (DOC, jail, mental health commitments, chemical dependency commitments, protection orders, etc.):

| Is person on a Court Order or LRA? ☐ Yes ☐ No | NAME OF CORRECTIONS OFFICER OR LRA MONITORING AGENCY | TELEPHONE NUMBER |
|---|---|---|
| | | |

History of violent / dangerous behaviors:

Is this individual a Community Protection Participant (CPP)? ☐ Yes ☐ No
Describe CPP risks identified in the client's treatment plan, if applicable:

| CURRENT PRIMARY CARE PHYSICIAN | TELEPHONE NUMBER |
|---|---|
| | |
| CURRENT MH PRESCRIBER | TELEPHONE NUMBER |
| | |

Is the person ambulatory? ☐ Yes ☐ No
Does the person use durable medical or other adaptive equipment? ☐ Yes ☐ No
If yes, describe:

Is the person willing to take medications as prescribed? ☐ Yes ☐ No
Date of last medication review:

Known Appointments Scheduled (who / where / when):

Treatment plan / goals for the Mobile Diversion Services:

Safety considerations when approaching home / location?

Other important information:

Hobbies / Interests:

Favorite Foods:

Favorite Places:

Dislikes:

Information Checklist (documents to be included as appropriate):

- ☐ Signed Physician's Orders (durable medical equipment, medication, etc.)
- ☐ Cross System Crisis Plan
- ☐ Functional Assessment
- ☐ Positive Behavior Support Plan
- ☐ Individual Instruction and Support Plan (IISP)
- ☐ DDA Assessment Details and Service Summary
- ☐ Psychiatric / Psychological Evaluations
- ☐ Community Protection Treatment Plan and Current Risk Assessment
- ☐ Guardianship Documentation, if applicable
- ☐ Current Medication Record
- ☐ Other (specify):

| SIGNATURE OF PERSON COMPLETING FORM | TITLE | DATE |
|---|---|---|
| | | |

**TO BE FILLED OUT BY MOBILE DIVERSION PROVIDER**

Person accepted? ☐ Yes ☐ No

| PROVIDER SIGNATURE | TITLE | DATE |
|---|---|---|
| | | |