DHS-DD-770

REQUEST FOR ADMISSION TO SDDC

Division of Developmental Disabilities
Department of Human Services

Provider Agency: _____ Contact Person: _____

Phone: _____ Email: _____

SERVICES REQUESTED FOR:

Name: _____ DOB: _____

Address: _____

REASON FOR REQUEST (How did team determine an admission is needed?):

_____

_____

***Description of agency plans for involvement with SDDC during the person's stay to ensure transition back to the provider agency**:*

_____

_____

SUBMITTED BY (CFCM): _____ Date: _____

CSP Representative: _____

DDD Program Specialist: _____ Contact: _____

REVIEWED BY: _____ Date: _____

☐ APPROVED ☐ DENIED *(check one)* Date Sent to SDDC: _____

PLEASE ATTACH THE FOLLOWING *(if applicable):*

Please mark an **X** next to the items you have included *(or note the date they may be provided).*

☐ a) Physical examination within the last 12 months;
☐ b) Current medical tests and results;
☐ c) Current medication orders and medication history;
☐ d) Most recent psychiatric and psychological evaluation, including all historical information related to issues requiring the consult;
☐ e) Psychiatric, psychologist, and/or counselor notes for the last 60 days *(if applicable);*
☐ f) Nursing notes for the last 60 days *(if applicable);*
☐ g) Specific description of the challenging behavior(s), including history of behavior;
☐ h) Individual Service Plan, sections relevant to specific issues requiring the admission;
☐ i) Summary of incident reports related to the identified behavior challenge(s);
☐ j) Current behavior plan with monthly progress reports for past six months and functional

SDDC Admission Checklist:

- Consents
- Commitment Order (if applicable)
- Social History or Social Evaluation
- Current Medications
- Pharmacy currently utilized
- Immediate Contact Person
- Most recent Psychological
- Medication History
- Current Physical
- Birth Certificate
- Social Security Card
- Immunization Record
- Medicaid Card/Medicare Part D insurance plan card
- Copy of Picture ID (if available)
- Guardianship papers (if applicable)
- For those people who do not have guardians, please have Dr. write up indication whether or not the person can give consent for Health Care and Psychotropic Medications.
- For those under 21 years of age, High School Transcript and IEP.
- Date of Last Vision Exam: _ _____

Additional Services Needed:

☐ Physical Therapy
☐ Occupational Therapy
☐ Speech
☐ Special Diet
☐ Alcohol or Drug Concerns
☐ Sexual Concerns