Opal Services Placement Application

APPLICANT INFORMATION

Name:	D.O.B.	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married
Current Address:		Phone Number:	
Reason Seeking Placement:			

Billing Procedure (Check One): ☐ Waiver Billing ☐ CADI ☐ DD ☐ OTHER: _____ (specify)	Billing Contact / Role Name: Address: Phone Number:
Legal Representative (if other than self) Name: Address: Phone Number:	County of Financial Responsibility:
Name and contact information for family members or significant others involved in this applicant's care or planning:	County Case Manager Name: Address: Phone Number:
	Second County Case Manager Name: Address: Phone Number:

MEDICAL INFORMATION

Physician Name	Clinic	Phone
Primary		
Specialists		
Dentist		
Eye Doctor		
Psychiatrist		

Known Medical Diagnosis	**KNOWN ALLERGIES**

Significant medical history and current medical concerns
(example:. thyroid removed at age 20 due to cancer, hasn't seen dentist in 5 years, artificial limbs/hips/etc., mobility issues)

☐ Takes Medications (list meds taken on last page of this form) ☐ Takes No Medications	Special Diet : ☐ Diabetic ☐ Low Sodium ☐ Low Fat ☐ Other *(list)* _____

Areas of Concern

☐ Chemical Abuse	☐ Behaviors / Issues	☐ Incontinence	☐ Dementia	☐ Ambulation
☐ Mental Health	☐ Physical Disability	☐ Hearing	☐ Sight	☐ Speech

Hospital Preference	Description of Undesirable Behaviors (if applicable)

RESIDENTIAL HISTORY

Include placements, own apartment/home, family home (include at least 10 years), or homeless

From (Month/Year)	To (Month/Year)	Name / Address
Telephone # ( )		Reason for leaving
From (Month/Year)	To (Month/Year)	Name / Address
Telephone # ( )		Reason for leaving
From (Month/Year)	To (Month/Year)	Name / Address
Telephone # ( )		Reason for leaving
From (Month/Year)	To (Month/Year)	Name / Address
Telephone # ( )		Reason for leaving

List additional residences on the back of this form.

HOSPITALIZATION HISTORY

Include at least 10 years

From (Month/Year)	To (Month/Year)	Name / Location	Reason for Hospitalization
From (Month/Year)	To (Month/Year)	Name / Location	Reason for Hospitalization
From (Month/Year)	To (Month/Year)	Name / Location	Reason for Hospitalization
From (Month/Year)	To (Month/Year)	Name / Location	Reason for Hospitalization

List additional hospitalizations on the back of this form. Attach assessments and discharge summaries. If hospitalization involved commitment, attach commitment paperwork and applicable Jarvis orders.

List Medications Taken / Purpose

_____

_____

_____

_____

_____

_____

CRIMINAL HISTORY

- Does applicant have a criminal record? _____
- Is applicant currently on probation? _____

  If Yes, please list all charges, convictions, incarcerations, probations, etc.

_____

_____

_____

_____

_____

PLEASE ATTACH COPIES OF:

- Most recent psychological evaluation / diagnostic assessment
- IEP/school records (if applicable)
- Individual Abuse Prevention Plan and Self-Management Assessment
- Coordinated Service and Support Plan (CSSP)
- MN Choices Assessment
- Coordinated Service and Support Plan Addendum (CSSP Addendum)
- Behavior Support Plan / Behavior Programming
- Quarterly Progress Reviews
- Psychotropic Medication Monitoring / side effect monitoring
  - Informed consent
  - MOSES
  - DISCUS
  - Psychotropic Medication Reviews
- Progress Notes from psychiatrist / therapist

_____ _____

Signature of Applicant Date

_____ _____

Signature of Legal Representative Date