ICF/IID PROGRAM

Identification and Demographic Information Fact Sheet

This form is being submitted: ☐As part of a full application ☐ As a correction or update

Participant's Name_____ Date: _____
First *Last* *Middle Initial*

Service Coordination Agency_____ SS#_____

Medicaid #_____ DOB_____ Sex: ☐ Male ☐Female

Residential Provider_____
Phone_____

Address_____ County DHHR_____

Type of Residence: ☐NF ☐SFCH ☐GH ☐ISS ☐Other _____

Date of Residential Placement_____ Prior Institutionalization ☐Yes ☐No

Name of Last Facility _____

Legal Representative_____

Address _____

Phone_____ Relationship to Participant_____

Monthly Average Income $_____

Financial Resources: ☐Trust ☐Medicaid ☐Medicare ☐Private Pay Insurance ☐SSI
☐SSDI ☐SSA ☐Handicapped Children Services ☐Other

Service Coordinator_____Phone_____

Regional Advocate_____Phone_____

Representative Payee_____Phone_____

Client Needs Summary for ICF/IID Placement

____ DD-1 (**Identification and Demographic Information Fact Sheet)**

____ DD-2A **(Annual Medical Evaluation)**

____ DD-3 **(Comprehensive Psychological Evaluation (Triennial))**

____ DD-4 **(Social History)**

____ DD-5 **(IPP)**

____ DD-7 **(ICF/IID (Admittance/Discharge/Transfer Tracking Form)**