

Connecticut Department of Mental Health and Addiction Services
DDaP – ABBREVIATED ADMISSION FORM



DEMOGRAPHICS

NAME (Last, First, optional MI): _____
*Required

SOCIAL SECURITY NUMBER: _____ - _____ - _____

NO SSN GIVEN / REASON: ☐ UNKNOWN ☐ NOT COLLECTED ☐ CLIENT REFUSED
*Required if no SSN given

DATE OF BIRTH: _____ / _____ / _____

NO DOB GIVEN / REASON: ☐ UNKNOWN ☐ NOT COLLECTED ☐ CLIENT REFUSED
*Required if no DOB given

RELIGION: (check one box only)

- | | |
|--|---|
| 01 ☐ PROTESTANT | 07 ☐ ORTHODOX |
| 02 ☐ CATHOLIC | 08 ☐ HINDU |
| 03 ☐ JEWISH | 10 ☐ PENTECOSTAL |
| 04 ☐ MUSLIM | 95 ☐ NONE |
| 05 ☐ BUDDHIST | 96 ☐ OTHER |
| 06 ☐ MORMON | 97 ☐ UNKNOWN |

MARITAL STATUS: (check one box below)

- | | |
|---|---|
| 01 ☐ NEVER MARRIED | 08 ☐ WIDOWED |
| 02 ☐ MARRIED | 09 ☐ CIVIL UNION |
| 03 ☐ SEPARATED | 96 ☐ OTHER |
| 04 ☐ DIVORCED/ANNULLED | 97 ☐ UNKNOWN |

*Required

ETHNIC ORIGIN: (check one box only)

- | | |
|---|--|
| 01 ☐ HISPANIC OTHER | 04 ☐ HISPANIC MEXICAN |
| 02 ☐ NON-HISPANIC | 05 ☐ HISPANIC CUBAN |
| 03 ☐ HISPANIC PUERTO RICAN | 97 ☐ UNKNOWN |

*Required

LANGUAGE: (check one Primary box, check one Secondary box, as applicable)							
	Primary	Secondary		Primary	Secondary		
16	☐	☐	CANTONESE	05	☐	☐	POLISH
43	☐	☐	ENGLISH	04	☐	☐	PORTUGUESE
03	☐	☐	FRENCH	20	☐	☐	RUSSIAN
07	☐	☐	GREEK	42	☐	☐	SIGN LANGUAGE
41	☐	☐	HAITIAN CREOLE	01	☐	☐	SPANISH
02	☐	☐	ITALIAN	10	☐	☐	VIETNAMESE
17	☐	☐	JAPANESE	96	☐	☐	OTHER
11	☐	☐	LAOTIAN	97	☐	UNKNOWN	
23	☐	☐	LATVIAN	44	☐	NONE	
15	☐	☐	MANDARIN				

*Primary Language Required

VETERAN: ☐ YES ☐ NO ☐ UNKNOWN

*Required

MILITARY START DATE: _____ / _____ / _____

*START DATE required if Veteran = Yes.

MILITARY END DATE: _____ / _____ / _____

RACE: (check all appropriate boxes)					
01	☐	AMERICAN INDIAN/NATIVE ALASKAN	06	☐	WHITE/CAUCASIAN
02	☐	ASIAN	96	☐	OTHER
03	☐	BLACK/AFRICAN AMERICAN	97	☐	UNKNOWN
04	☐	NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER			

*Required

GENDER: ☐ FEMALE ☐ MALE ☐ UNKNOWN

*Required

PROVIDER CLIENT ID:

ADDRESS:		
CLIENT STREET ADDRESS 1:		
CLIENT STREET ADDRESS 2:		
CITY:	STATE:	ZIP CODE:

*Required

INSURANCE INFORMATION

(Select Insurance Type 1 - 4, as applicable)

INSURANCE TYPE(S) used by clients		INSURANCE TYPE 1	INSURANCE TYPE 2	INSURANCE TYPE 3	INSURANCE TYPE 4
02	NO HEALTH INSURANCE	☐			
04	OTHER PRIVATE INSURANCE	☐	☐	☐	☐
05	MEDICARE	☐	☐	☐	☐
06	CHAMPUS (U.S. Military)	☐	☐	☐	☐
08	MEDICAID HUSKEY C*	☐	☐	☐	☐
09	HMO (including Managed Medicaid)	☐	☐	☐	☐
12	GA-SAGA (General Assistance- State Administered)	☐	☐	☐	☐
14	ATR (Access to Recovery)	☐			
15	SELF PAY	☐			
16	MEDICAID LIA HUSKEY D*	☐	☐	☐	☐
17	MEDICARE PART A	☐	☐	☐	☐
18	MEDICARE PART B	☐	☐	☐	☐
19	MONEY FOLLOWS THE PERSON (MFP)				
20	NURSING HOME WAIVER				
21	Medicaid BHH	☐	☐	☐	☐
22	Medicaid-Husky A	☐	☐	☐	☐
23	MEDICAID BHH - WAIVER	☐	☐	☐	☐
96	OTHER	☐	☐	☐	☐
97	UNKNOWN	☐			

**Policy Number is required if INSURANCE TYPE is MEDICAID.*

(Complete based on corresponding INSURANCE TYPE selected, except 02, 97, 14, 15)

INSURANCE TYPE 1

<u>POLICY NUMBER</u> : (if applicable)	
<u>INSURANCE POLICY START DATE</u> :	____ / ____ / ____
<u>INSURANCE POLICY END DATE</u> :	____ / ____ / ____

INSURANCE TYPE 2

<u>POLICY NUMBER</u> : (if applicable)	
<u>INSURANCE POLICY START DATE</u> :	____ / ____ / ____
<u>INSURANCE POLICY END DATE</u> :	____ / ____ / ____

INSURANCE TYPE 3

<u>POLICY NUMBER</u> : (if applicable)	
<u>INSURANCE POLICY START DATE</u> :	____ / ____ / ____
<u>INSURANCE POLICY END DATE</u> :	____ / ____ / ____

INSURANCE TYPE 4

<u>POLICY NUMBER</u> : (if applicable)	
<u>INSURANCE POLICY START DATE</u> :	____ / ____ / ____
<u>INSURANCE POLICY END DATE</u> :	____ / ____ / ____

ADMISSION

ADMISSION PROGRAM: _____

*Required

ADMISSION DATE: ____ / ____ / ____

*Required

DATE OF FIRST SERVICE REQUEST: ____ / ____ / ____

*Required

PRIMARY REFERRAL SOURCE: (check one box below)

- | | |
|---|--|
| 01 ☐ SELF | 11 ☐ DEPT OF SOCIAL SERVICES |
| 02 ☐ FAMILY/FRIEND | 12 ☐ DEPT OF DEVELOPMENTAL DISABILITIES |
| 03 ☐ MENTAL HEALTH PROVIDER | 13 ☐ OTHER COMMUNITY REFERRAL |
| 04 ☐ ADDICTION SERVICES PROVIDER | 14 ☐ COURT ORDER |
| 05 ☐ MEDICAL HEALTH PRACTITIONER | 15 ☐ PROBATION/PAROLE |
| 06 ☐ SCHOOL | 16 ☐ POLICE |
| 07 ☐ EMPLOYER/SUPERVISOR | 17 ☐ SHELTER |
| 08 ☐ EMPLOYEE ASSISTANCE PROGRAM | 18 ☐ DEPARTMENT OF CORRECTIONS (DOC) |
| 09 ☐ CLERGY/CHURCH/SYNAGOGUE | 96 ☐ OTHER |
| 10 ☐ DEPT OF CHILDREN AND FAMILIES | 97 ☐ UNKNOWN |

TOBACCO USE: ☐ YES ☐ NO ☐ UNKNOWN

PREGNANCY STATUS: ☐ YES ☐ NO ☐ UNKNOWN
(Required for Females)

PROVIDER SIGNATURE: _____

DATE: ____ / ____ / ____

DIAGNOSIS

EFFECTIVE DATE OF DIAGNOSIS: / /

*Required

(Enter Client's clinical diagnoses below.)

AXIS I	(Enter ICD 10 Diagnosis)	Description
1	_____.____.____ (Primary Dx)	_____
2	_____.____.____	_____
3	_____.____.____	_____
4	_____.____.____	_____
5	_____.____.____	_____
6	_____.____.____	_____
7	_____.____.____	_____

AXIS II	(Enter ICD 10 Diagnosis)	Description
1	_____ . _____	_____
2	_____ . _____	_____
3	_____ . _____	_____
4	_____ . _____	_____
5	_____ . _____	_____

AXIS III	(Enter ICD 10 Diagnosis)	Description
1	____ _ . ____ _	_____
2	____ _ . ____ _	_____
3	____ _ . ____ _	_____
4	____ _ . ____ _	_____
5	____ _ . ____ _	_____

AXIS IV (Select Yes or No)			
2	PROBLEMS RELATED TO THE SOCIAL ENVIRONMENT	☐ YES	☐ NO
1	PROBLEMS WITH PRIMARY SUPPORT GROUP	☐ YES	☐ NO
9	OTHER PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS	☐ YES	☐ NO
7	PROBLEMS WITH ACCESS TO HEALTH SERVICES	☐ YES	☐ NO
4	OCCUPATIONAL PROBLEMS	☐ YES	☐ NO
3	EDUCATIONAL PROBLEMS	☐ YES	☐ NO
6	HOUSING PROBLEMS	☐ YES	☐ NO
5	ECONOMIC PROBLEMS	☐ YES	☐ NO
8	PROBLEMS RELATED TO THE LEGAL SYSTEM / CRIME	☐ YES	☐ NO

AXIS V – GAF SCORE: (ENTER 0 – 100)