

Connecticut Department of Mental Health and Addiction Services

DDaP – 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 CHRISTIAN |
| 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:

(Optional field for Provider's use)

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

*Policy Number is required if INSURANCE TYPE is MEDICAID.

INSURANCE TYPE 2	
POLICY NUMBER : (if applicable)	
INSURANCE POLICY START DATE:	____ / ____ / ____
INSURANCE POLICY END DATE:	____ / ____ / ____
INSURANCE TYPE 3	
POLICY NUMBER : (if applicable)	
INSURANCE POLICY START DATE:	____ / ____ / ____
INSURANCE POLICY END DATE:	____ / ____ / ____
INSURANCE TYPE 4	
POLICY NUMBER : (if applicable)	
INSURANCE POLICY START DATE:	____ / ____ / ____
INSURANCE POLICY END DATE:	____ / ____ / ____

ADMISSION

ADMISSION PROGRAM: _____

*Required

ADMISSION DATE: _____ / _____ / _____

*Required

DATE OF FIRST SERVICE REQUEST: _____ / _____ / _____

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 ☐ SUBSTANCE ABUSE 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 |

*Required

TOBACCO USE:

☐ YES ☐ NO ☐ UNKNOWN

PREGNANCY STATUS:

☐ YES ☐ NO ☐ UNKNOWN

(Required for Females)

DIAGNOSIS

EFFECTIVE DATE OF DIAGNOSIS: _____ / _____ / _____

*Required

(Enter Client's clinical diagnoses below.)

AXIS I	(Enter ICD 10 Diagnosis)	Description
1	_____._____._____._____._____. (*Primary Dx Required)	_____
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
5	HOUSING PROBLEMS	☐ YES	☐ NO
6	ECONOMIC PROBLEMS	☐ YES	☐ NO
8	PROBLEMS RELATED TO THE LEGAL SYSTEM / CRIME	☐ YES	☐ NO

AXIS V – GAF SCORE: (ENTER 0.00 – 100.00)

*Required based on Treatment Related or LOC Mode (enter Zero if no assessment performed)

PERIODIC ASSESSMENT

*Required based on Treatment Related or LOC Mode

ASSESSMENT DATE: _____ / _____ / _____

*Required if PA required

EMPLOYMENT STATUS: (check one box only)

30	☐	EMPLOYMENT FULL TIME (in competitive employment)	46	☐	NOT IN LABOR FORCE; retired
32	☐	EMPLOYMENT PART TIME (in competitive employment)	48	☐	NOT IN LABOR FORCE; SSI SSDI
34	☐	UNEMPLOYMENT (looking for work in the past 30 days, or on a layoff)	50	☐	NOT IN LABOR FORCE; Inmate of institution
36	☐	PAID BUT NON-COMPETITIVE WORK (transitional employment programs)	52	☐	NOT IN LABOR FORCE; other reason
38	☐	PAID BUT NON-COMPETITIVE WORK (work inside the clubhouse or treatment agency, mobile work crews and consumer-run businesses)	96	☐	OTHER
42	☐	NOT IN LABOR FORCE; student enrolled in a school or job training program)	97	☐	UNKNOWN
44	☐	NOT IN LABOR FORCE; homemaker			

*Required if PA required

HIGHEST GRADE COMPLETED: Highest school grade completed by Client at the time of Assessment. (Enter 0 – 32)

☐ UNKNOWN

*Required if PA required

PERSONS DEPENDENT ON INCOME: (Enter 1 – 15)

*Required if PA required

MINORS DEPENDENT ON INCOME: (Enter 0 – 14)

PRINCIPAL SOURCE OF SUPPORT: (check one box only)

0	☐	NONE	4	☐	DISABILITY
1	☐	PUBLIC ASSISTANCE	96	☐	OTHER
2	☐	RETIREMENT	97	☐	UNKNOWN
3	☐	SALARY			

*Required if PA required

LIVING SITUATION: (check one box only)

30	☐	PRIVATE RESIDENCE, client owns or holds lease	46	☐	PSYCHIATRIC/SA/MEDICAL INPATIENT
32	☐	PRIVATE RESIDENCE, friend or relative owns the residence or holds lease.	47	☐	TEMPORARILY HOUSED (temporarily with friends/family sleeping on couch, no designated space of their own)
34	☐	SINGLE ROOM OCCUPANCY (Hotel, YMCA, Rooming House)	48	☐	CORRECTIONAL INSTITUTION
36	☐	PRIVATE RESIDENCE, Community agency owns or holds lease	50	☐	DOMESTIC VIOLENCE SHELTER
38	☐	RESIDENTIAL CARE HOME / BOARD AND CARE	52	☐	HOMELESS SHELTER
40	☐	CONGREGATE RESIDENTIAL CARE (24-hour supervision, group setting, services focus on MH, SA, &/or MR issues, Recovery House.)	54	☐	HOMELESS (including on street)
42	☐	CRISIS / RESPITE BED	96	☐	OTHER

44 ☐ SKILLED NURSING FACILITY/ INTERMEDIATE CARE FACILITY/ NURSING HOME	97 ☐ UNKNOWN
--	---

*Required if PA required

Was Client Homeless in the Last Six Months?

☐ YES ☐ NO ☐ UNKNOWN

**Number of Days in the Last 30 that client lived in a
Controlled Environment?**

(Enter 0 – 30)

Number of Arrests in the Last 30 Days?

(Enter 0 – 30) ☐ UNKNOWN

*Required if PA required

**SOCIAL SUPPORT VOLUNTARY: Number of Self-Help
programs/meetings attended in last 30 days**

(Enter 0 – 90) ☐ UNKNOWN

*Required if PA required

**SOCIAL SUPPORT FAMILY/FRIENDS: Indicate whether
or not Client interacted with Family/Friends supportive
of recovery in the thirty days preceding assessment.**

☐ YES ☐ NO ☐ UNKNOWN

*Required if PA required

SUBSTANCE ABUSE

(Select client's lifetime number of prior Admissions to Inpatient/Residential Substance Abuse treatment.)

SA IP.RES. ADMISSIONS: LIFETIME

0 ☐ NO PRIOR ADMISSIONS	04 ☐ 4 PRIOR ADMISSIONS
01 ☐ 1 PRIOR ADMISSION	05 ☐ 5 PRIOR ADMISSIONS
02 ☐ 2 PRIOR ADMISSIONS	06 ☐ GREATER THAN 5 PRIOR ADMISSIONS
03 ☐ 3 PRIOR ADMISSIONS	97 ☐ UNKNOWN

(Select client's lifetime number of prior Admissions to Outpatient Substance Abuse treatment.)

SA OP.RES. ADMISSIONS: LIFETIME

0 ☐ NO PRIOR ADMISSIONS	04 ☐ 4 PRIOR ADMISSIONS
01 ☐ 1 PRIOR ADMISSION	05 ☐ 5 PRIOR ADMISSIONS
02 ☐ 2 PRIOR ADMISSIONS	06 ☐ GREATER THAN 5 PRIOR ADMISSIONS
03 ☐ 3 PRIOR ADMISSIONS	97 ☐ UNKNOWN

*Required if PA required for SUD programs or SUD primary dx

PERIODIC ASSESSMENT – SUBSTANCE USE

(Select Drug Type 1 - 5, as applicable)

DRUG TYPE(S) used by clients		DRUG TYPE 1	DRUG TYPE 2	DRUG TYPE 3	DRUG TYPE 4	DRUG TYPE 5
0	NONE	☐				
01	AMPHETAMINES	☐	☐	☐	☐	☐
02	ALCOHOL	☐	☐	☐	☐	☐
03	BARBITUATES	☐	☐	☐	☐	☐
04	BENZODIAZEPINES	☐	☐	☐	☐	☐
05	COCAINE	☐	☐	☐	☐	☐
06	CRACK	☐	☐	☐	☐	☐
07	HALLUCINOGENS: LSD, DMS, STP, etc.	☐	☐	☐	☐	☐
08	HEROIN	☐	☐	☐	☐	☐
09	INHALANTS	☐	☐	☐	☐	☐
10	MARIJUANA, HASHISH, THC	☐	☐	☐	☐	☐
11	METHAMPHETAMINES	☐	☐	☐	☐	☐
12	NON-PRESCRIPTIVE METHADONE	☐	☐	☐	☐	☐
13	OTHER OPIATES AND SYNTHETICS	☐	☐	☐	☐	☐
14	OTHER SEDATIVES OR HYPNOTICS	☐	☐	☐	☐	☐
15	OTHER STIMULANTS	☐	☐	☐	☐	☐
16	OVER THE COUNTER	☐	☐	☐	☐	☐
17	PCP	☐	☐	☐	☐	☐
18	TRANQUILIZERS	☐	☐	☐	☐	☐
19	TOBACCO	☐	☐	☐	☐	☐

*DRUG TYPE 1: Required if PA required for SUD programs or SUD primary dx

DRUG METHOD USE FIELD 1: (Complete based on corresponding DRUG TYPE 1 selected, except 0 & 97.)

01	☐	ORAL	04	☐	INJECTION
02	☐	SMOKING	96	☐	OTHER
03	☐	INHALATION	97	☐	UNKNOWN

DAYS USED FIELD 1:

Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 1 field? *(Enter 0 – 30)*

AGE FIRST USED FIELD 1:

Age at which the client used the Drug specified in the Drug Type 1 field? *(Enter Age)*

*DRUG TYPE 1: Required if PA required for SUD programs or SUD primary dx

DRUG METHOD USE FIELD 2: (Complete based on corresponding DRUG TYPE 2 selected, except 0 & 97.)			
01	☐	ORAL	
02	☐	SMOKING	
03	☐	INHALATION	
04	☐	INJECTION	
96	☐	OTHER	
97	☐	UNKNOWN	
<u>DAYS USED FIELD 2:</u> Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 2 field? (Enter 0 – 30) <u>AGE FIRST USED FIELD 2:</u> Age at which the client used the Drug specified in the Drug Type 2 field? (Enter Age)			

DRUG METHOD USE FIELD 3: (Complete based on corresponding DRUG TYPE 3 selected, except 0 & 97.)			
01	☐	ORAL	
02	☐	SMOKING	
03	☐	INHALATION	
04	☐	INJECTION	
96	☐	OTHER	
97	☐	UNKNOWN	
<u>DAYS USED FIELD 3:</u> Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 3 field? (Enter 0 – 30) <u>AGE FIRST USED FIELD 3:</u> Age at which the client used the Drug specified in the Drug Type 3 field? (Enter Age)			

DRUG METHOD USE FIELD 4: (Complete based on corresponding DRUG TYPE 4 selected, except 0, 97.)			
01	☐	ORAL	
02	☐	SMOKING	
03	☐	INHALATION	
04	☐	INJECTION	
96	☐	OTHER	
97	☐	UNKNOWN	
<u>DAYS USED FIELD 4:</u> Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 4 field? (Enter 0 – 30) <u>AGE FIRST USED FIELD 4:</u> Age at which the client used the Drug specified in the Drug Type 4 field? (Enter Age)			

DRUG METHOD USE FIELD 5: (Complete based on corresponding DRUG TYPE 5 selected, except 0 & 97.)			
01	☐	ORAL	
02	☐	SMOKING	
03	☐	INHALATION	
04	☐	INJECTION	
96	☐	OTHER	
97	☐	UNKNOWN	
<u>DAYS USED FIELD 5:</u> Number of Days in the Last 30 in which the client used the Drug specified in the Drug Type 5 field? (Enter 0 – 30) <u>AGE FIRST USED FIELD 5:</u> Age at which the client used the Drug specified in the Drug Type 5 field? (Enter Age)			

CO-OCCURRING SCREENING

CO-OCCURRING SCREENING DATE: _____ / _____ / _____

*All other components required if Co-Occurring screening date is entered in DDaP

MENTAL HEALTH

MH SCREENING USED: *(check one box only)*

- | | | | | | |
|----|--------------------------|--------------------------------|----|--------------------------|---------------------------------------|
| 01 | ☐ | MENTAL HEALTH SCREEN FORM III* | 02 | ☐ | MODIFIED MINI* |
| 08 | ☐ | DECLINED | 09 | ☐ | MEDICALLY OR CLINICALLY INAPPROPRIATE |

MH SCREENING SCORE: *(*Required if MH SCREENING USED field is a value of 1 or 2.)*

MENTAL HEALTH SCREEN FORM III SCORE: (Enter 0-16)

MODIFIED MINI SCORE: (Enter 0-23)

MH SCREEN MOD MINI # 4: *(Yes Response to Suicidality)*

☐ YES ☐ NO

MH SCREEN MOD MINI # 14 and # 15: *(Yes Response to 2 Trauma Questions on Modified Mini Survey)*

☐ YES ☐ NO

MH SCREEN Gambling Question Response: *(Yes Response to Form III # 16 or Modified # 23 related to gambling)*

☐ YES ☐ NO

SUBSTANCE ABUSE

SA SCREENING USED: *(check one box only)*

- | | | | | | |
|----|--------------------------|-------------------------|----|--------------------------|---------------------------------------|
| 01 | ☐ | SSI ALCOHOL AND DRUGS** | 02 | ☐ | CAGE – Adapted to Include Drugs** |
| 08 | ☐ | DECLINED | 09 | ☐ | MEDICALLY OR CLINICALLY INAPPROPRIATE |

SA SCREENING SCORE: *(**Required if SA SCREENING USED field is a value of 1 or 2.)*

SSI ALCOHOL AND DRUG SCREENING SCORE: (Enter 0-14)

CAGE - Adapted to Include Drugs screening SCORE (Enter 0-8)

PROVIDER SIGNATURE: _____

DATE: _____ / _____ / _____