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

DEMOGRAPHICS

NAME: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

NO SSN GIVEN / REASON: ☐ UNKNOWN ☐ NOT COLLECTED ☐ CLIENT REFUSED

DATE OF BIRTH: _____ / _____ / _____

NO DOB GIVEN / REASON: ☐ UNKNOWN ☐ NOT COLLECTED ☐ CLIENT REFUSED

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

ETHNIC ORIGIN: *(check one box only)*					
01	☐	HISPANIC OTHER	04	☐	HISPANIC MEXICAN
02	☐	NON-HISPANIC	05	☐	HISPANIC CUBAN
03	☐	HISPANIC PUERTO RICAN	97	☐	UNKNOWN

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**				

VETERAN: ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

MILITARY START DATE: _____ / _____ / _____

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**			

GENDER: ☐ **FEMALE** ☐ **MALE** ☐ **UNKNOWN**

PROVIDER CLIENT ID: _____

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

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	☐	☐	☐	☐
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: _____ / _____ / _____

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: _____

ADMISSION DATE: _____ / _____ / _____

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	☐	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: _____ / _____ / _____

(Enter Client's clinical diagnoses below.)

AXIS I	*(Enter Diagnosis)*	Description
1	___ ___ ___.___ ___ **(Primary Dx)**	
2	___ ___ ___.___ ___	
3	___ ___ ___.___ ___	
4	___ ___ ___.___ ___	
5	___ ___ ___.___ ___	
6	___ ___ ___.___ ___	
7	___ ___ ___.___ ___	

AXIS II	*(Enter Diagnosis)*	Description
1	___ ___ ___.___ ___	
2	___ ___ ___.___ ___	
3	___ ___ ___.___ ___	
4	___ ___ ___.___ ___	
5	___ ___ ___.___ ___	

AXIS III	*(Enter 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)*** ☐