

State of Montana
Developmental Disabilities Program
Social History
Do not alter this form

DPHHS CM-1
Rev. 3-20-2018

Case Manager: _____ **Phone:** _____ **Date Completed:** _____

Individual Information:

Name: _____ Social Security Number: _____

Address: _____

Phone: _____ DOB: _____ Sex: _____ Height: _____ Weight: _____

Marital Status: _____ Spouse Name: _____

Legal Guardian: _____

Relationship to Person: _____ Phone: _____

Guardian Address: _____

Medicaid Number: _____ **Medicare Number:** _____

Burial Fund: Yes No Trust Fund: Yes No Life Insurance: Yes No

Primary Disability: _____ Diagnostic Code: _____

Secondary Disabilities: _____

Primary Doctor/Dentist:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Other Doctors/Counselors Involved:

_____ Phone: _____

_____ Phone: _____

Hospital Preference: _____ Phone: _____

Insurance Name/Address: _____

Group #: _____ Policy #: _____

Referral Source:

Name _____ Relationship _____

Address _____ Phone _____

Family and Significant Others to Client in Priority of Emergency Contact:

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

Family Interest: Strong Interest No Contact Some Interest No Known Relatives

State of Montana
Developmental Disabilities Program
Social History
Do not alter this form

Financial: (check those that apply)

- | | | | |
|-----------------|--|--|---------------------------------|
| Medicaid | <input type="checkbox"/> Receives Amount _____ | <input type="checkbox"/> Has Applied For | <input type="checkbox"/> Denied |
| Social Security | <input type="checkbox"/> Receives Amount _____ | <input type="checkbox"/> Has Applied For | <input type="checkbox"/> Denied |
| SSI | <input type="checkbox"/> Receives Amount _____ | <input type="checkbox"/> Has Applied For | <input type="checkbox"/> Denied |
| Medically Needy | <input type="checkbox"/> Receives Amount _____ | <input type="checkbox"/> Has Applied For | <input type="checkbox"/> Denied |
| Other _____ | <input type="checkbox"/> Receives Amount _____ | <input type="checkbox"/> Has Applied For | <input type="checkbox"/> Denied |

Name of Payee: _____

Current Services and Supports and/or Educational/Vocational Status:

Services Desired:

Check here if serious maladaptive behaviors.
 (Describe in #10 of Social History)

Check here if serious medical problems.
 (Describe in #5 & #6 of Social History)

Special Aids or Equipment Used: (Please check if any of the following are used/needed.)

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Walker | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Artificial Limbs |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Special Bed | <input type="checkbox"/> Ileostomy Equipment | <input type="checkbox"/> Head Protective Device |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Special Chair | <input type="checkbox"/> Colostomy Equipment | <input type="checkbox"/> Positioning Equipment |
| <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Gastrostomy Equipment | <input type="checkbox"/> Communication Aid |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Catheter (Bladder) | <input type="checkbox"/> Belly Board | <input type="checkbox"/> Special Eating Utensils |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Electric Wheelchair | <input type="checkbox"/> Orthopedic Shoes | <input type="checkbox"/> Other (specify): |

Medications:

List the medications the individual receives and reason (e.g. behavior control, seizure):

| Medication | Reason |
|------------|--------|
| | |
| | |
| | |
| | |
| | |
| | |

State of Montana
Developmental Disabilities Program
Social History
Do not alter this form

1. Describe individual's current living arrangement.

2. Describe where the individual was born and spent formative years, and when the primary/secondary disability was first noted by family and doctor. Describe any significant events that have occurred in his/her life.

3. List education, special education and related services provided to the individual, including all residential placements outside the family home with dates of placements.

4. List other agencies in which the person is or has been involved (current and past) with the phone number and name of a contact person for each agency.

5. Describe the current medical status and history for the individual including: allergies, medical/dental limitations, recent hospitalizations and surgeries, special diet, nutrient requirements, the need for invasive procedures, high blood pressure, etc. If possible, summarize the results of physical examinations, OT, PT, speech, nutritional and other pertinent evaluations.

6. Describe how often individual needs medical/mental health services.

7. Describe ability level of the individual, noting the areas in which he/she does well (strengths) and the areas he/she needs assistance and further training.

8. Describe individual characteristics of the person including such things as preferred learning style, events which may upset him/her, unique sense of humor, long/short-term retention, reading/writing skills, mode of communication, etc.

9. A. Describe the areas of vulnerability and risk to the individual. (e.g. sexual, financial, safety, etc.)

B. Is there a potential that the individual will abuse others or engage in illegal acts? Explain:

State of Montana
Developmental Disabilities Program
Social History

Do not alter this form

10. Describe in detail serious and minor problem behaviors that the individual currently exhibits or has exhibited in past. (Complete and attach the Behavioral Supplement when significant behaviors exist.)

11. Describe any alternatives available in the person's home community (if that is the person's desired place to live) and the status of attempts to secure those alternative services or supports.

12. Describe vocational interests and employment history of the individual (e.g. time on task without supervision, response to supervision, etc.)

13. List future goals, plans and/or dreams that this individual has.

14. List hobbies, other leisure time activities as well as social and recreation activities in which the person likes to participate given the opportunity to plan his/her free time.

15. List any environmental, cultural, spiritual, or other factors important to assisting the individual in a placement.

16. Provide recommendations for services and/or supports noting any special considerations such as medical services, peer/support group considerations, need for communication devices, recreational interests, etc.

17. Explain the impact for the individual if services are not received.

18. Provide the case manager's assessment concerning the individual's need, (frequency of contacts, intensity, etc.) for case management services. (Actual case plan is on DPHHS-CM-3 or IP)

Individual completing intake and social history:

| | |
|-----------------------------------|------|
| Case Manager Signature | Date |
| Case Manager Supervisor Signature | Date |