

Special Project Enrollment Form

General Information			
Facility: Select One		Service Provided: Select One	
Inpatient Project Type: ☐ Mental Health ☐ Substance Use Disorder		Funding Source: Select One	
Insurance: ☐ None ☐ Private Insurance ☐ Medicaid		Facility Record Number:	
Medicaid ID:			
Admission Date:		Primary Care Physician:	

Patient Information			
Name:			
	First	Middle Initial	Last
			Date of Birth:
	Maiden Name (if applicable)	Marital Status: Select One	
SSN:	Sex: ☐ Male ☐ Female	Pregnant: ☐ Yes ☐ No	
Address:	Street		City
			Phone Number:
	State	Zip Code	Living Arrangement: Select One
	Primary Language: Select One		
Proficient in English:			
Race: Select One	Ethnicity: Select One	Veteran: ☐ Yes ☐ No	
Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed		Guardian:	
Emergency Contact & Phone Number:			
Referral Source: Select One	Highest Grade Completed:	Special Accommodations: Wheelchair/Mo	

Current Risk Assessment					
1. Patient's potential risk to self	☐ None	☐ Mild	☐ Moderate	☐ Severe	
2. Patient's potential risk to others	☐ None	☐ Mild	☐ Moderate	☐ Severe	
3. Instability of care provider supervision	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Not Screened
4. Safety issues in living arrangement	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Not Screened
5. Aggression of self-injurious behaviors	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Not Screened
DSM-5 Diagnosis Code(s) (ICD-10):					

Substance Use Disorder Information			
IF YOU HAVE ENTERED A SUBSTANCE USE DISORDER(S)/DIAGNOSIS ABOVE, YOU MUST ENTER THE SUBSTANCE USE INFORMATION BELOW ON EACH SUBSTANCE USE DISORDER			
Is patient in need of detox? ☐ Yes ☐ No ☐ N/A		Withdrawal Symptoms:	Select One Select One Select One
Drugs	Frequency of Use	Age of First Use	Route
Select One	Select One		Select One
Select One	Select One		Select One
Select One	Select One		Select One
Select One	Select One		Select One
Select One	Select One		Select One
Target Population:	☐ AMI/Mental Health	☐ Aster/Substance Use	☐ ADSN/Developmental Disorder
Presenting Problem:			
Name of Person Completing this Form:			Date: