

LCDAC Client Admission Form

ALL FIELDS ARE TO BE COMPLETED

Provider Name: _____

DDAP License #: _____

Client SCA #: _____

Request Information			
Level of Care Admitted To:	Service Requested (if different from current level of care):		
Admission Date (date LCDAC funding will begin):		Medicaid (MA) Status:	
MA Application Date:	Other Insurance:	Referral Source:	
Client Information			
First Name:	MI:	Suffix:	Birth Date:
Last Name:	SSN:		
Maiden/Birth:	Street Address:		
City:	State:	Zip Code:	
Demographics			
Race:	Ethnicity:	Sex:	
Marital Status:	# of Minor Children:	Pregnant:	
Priority Population Status:	Employment Status:		
Current Income:	# of Other Dependents:		
Highest Level of Education:	Living Arrangement:		
D&A/Psychiatric			
# of Prior Treatment Episodes:	Co-Occurring:		
If co-occurring, please explain:			
Substance Use at Admission			
<i>Primary Substance:</i>			
Route:	Frequency:	Last Use:	
<i>Secondary Substance:</i>			
Route:	Frequency:	Last Use:	
<i>Tertiary Substance:</i>			
Route:	Frequency:	Last Use:	