Education Addendum

Data Field	Client Information
Person's Name (First, MI, Last)	Record first name, middle initial, and last name of the person served. Order of name is at agency discretion.
Record Number	Record agency's established identification number for the person.
Date of Admission	Record date the person served was admitted.
Organization/ Program Name	Record the organization and program for whom you are delivering the service.
DOB	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.

Data Field	Education Addendum
Major/Degree(s)	Complete the name of the *Major(s)/Degree(s)* obtained and the year(s) completed.
Vocational Training	Check if none reported. Provide details if person is receiving vocational training, regardless of whether or not a certificate is received.
Vocational License(s)/ Certification(s)	If person engaged in vocational training complete the name of the license(s) or certificate(s) obtained and year completed.
Educational Interests/Skills	Check all boxes that apply and comment on specific issues/skills identified.
History of Learning Difficulties	Check all boxes that are pertinent to person's identified difficulties. This information may come from a variety of sources, including, but not limited to, the clinician conducting the intake. Include sources of information under "other/comments". **Example: Learning Disability- Type: dyslexia.** Note if it is a past or a current issue for person served. Identify if any special communication needs are present as well as need for assisted verbal devices or communication boards.
Barriers to Learning	Check all boxes that apply, or indicate "other" and comment on any barriers that may/have interfered on person's ability to learn new information. Example: English is not Tom's native language, so he often has difficulty understanding the material presented in class.

Data Field	Signatures
Person's Signature (Optional, if clinically appropriate)	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives.
Date	Date of Parent/Guardian Signature.
Clinician/Provider – Print Name/Credential	**Legible** clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor – Print	If applicable, **legibly** record signature and credentials of supervisor.

Name/Credential (if needed)	
Date	Date of this signature.
Clinician/Provider Signature	**Legible** signature, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor's Signature (if needed)	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**
Date	Date of this signature.
Physician/MD/DO Signature (if required)	**Legible** physician's signature if required by agency policy. Please note certain payers do require physician's signature. This is a requirement for Opiate Treatment Programs