

Part I: Demographics

First Name		Middle Initial	Last Name		Suffix
Mailing Address					
City		State	Zip	County	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Phone Number	Unique Identifier <input type="checkbox"/> Social Security Number <input type="checkbox"/> Passport ID <input type="checkbox"/> Temporary Resident ID <input type="checkbox"/> Driver's License/State ID <input type="checkbox"/> Medicaid ID <input type="checkbox"/> AssessmentPro IID <input type="checkbox"/> The individual doesn't have any of these IDs Identifier Number: _____				
Date of Birth	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				
Payment Method <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Self-Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid/Long-Term Care Pending Medicaid ID: _____ Medicare ID: _____			Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino/Spanish <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____		
Current Location <input type="checkbox"/> Community Setting <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Hospice Care Facility <input type="checkbox"/> Medical Facility Medical Unit <input type="checkbox"/> Medical Facility ER/ED <input type="checkbox"/> Medical Facility Psych Unit <input type="checkbox"/> Psychiatric Facility <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Shelter <input type="checkbox"/> PACE Facility <input type="checkbox"/> Home <input type="checkbox"/> SLP <input type="checkbox"/> SMHRF <input type="checkbox"/> Other (specify): _____			Current Location Address Admission Date Current Location Phone Number		
What has been his/her typical living situation over the past year? <input type="checkbox"/> Home alone <input type="checkbox"/> Home w/natural supports <input type="checkbox"/> Home w/paid supports <input type="checkbox"/> Assisted living <input type="checkbox"/> Nursing facility <input type="checkbox"/> Shelter <input type="checkbox"/> Group home <input type="checkbox"/> Psychiatric facility <input type="checkbox"/> Correctional Facility <input type="checkbox"/> ICF/IID <input type="checkbox"/> SLP <input type="checkbox"/> SMHRF <input type="checkbox"/> Homelessness <input type="checkbox"/> Other (specify): _____					
Prospective SLP Name			Prospective SLP Address		

Part II: Reason for Screening

- ☐ Preadmission Screen: Initial Screening for SLP setting participation
☐ Transfer: Nursing Facility to SLP Setting
☐ Transfer: SLP setting to SLP setting
☐ Expiration of prior SLP screen or assessment
☐ Conversion: Private pay SLP participant converting to Medicaid

Part III: Reasonable Basis To Suspect A Developmental Disability

The individual has been formally diagnosed with Intellectual Disability (ID), Developmental Disability (DD) such as Cerebral Palsy, Epilepsy, Autism, or any other condition (other than mental illness) found to be closely related to ID/DD because this condition results in impairments of general intellectual functioning or adaptive behavior similar to that of individuals with Intellectual Disability and requires services similar to those required for such individuals AND the condition was manifested prior to the age of 22	<input type="checkbox"/> No <input type="checkbox"/> Yes. Indicate applicable condition: <input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Developmental Disability (DD) <input type="checkbox"/> Other (specify): _____
The individual experienced seizures prior to the age of 22.	<input type="checkbox"/> No <input type="checkbox"/> Yes
The individual has received special education and/or day program services.	<input type="checkbox"/> No <input type="checkbox"/> Yes
The individual remained at home with family and did not go to school or work.	<input type="checkbox"/> No <input type="checkbox"/> Yes

Last Name_____First Name_____DOB_____	
There are other indicators of intellectual or developmental disability.	<input type="checkbox"/> No <input type="checkbox"/> Yes. Specify other indicator(s):

Part IV: Reasonable Basis To Suspect A Mental Illness

The individual has been formally diagnosed with a mental illness verified by a DSM-IV classification which substantially impairs the person's cognitive, emotional and/or behavioral functioning, <u>excluding</u> organic disorders/dementia, developmental disabilities, and alcohol/substance abuse.	<input type="checkbox"/> No <input type="checkbox"/> Yes
The individual has a history of psychiatric hospitalization.	<input type="checkbox"/> No <input type="checkbox"/> Yes
The individual has a history of outpatient mental health services.	<input type="checkbox"/> No <input type="checkbox"/> Yes
There are other indicators of mental illness.	<input type="checkbox"/> No <input type="checkbox"/> Yes. Specify other indicator(s):

Guardianship & Physician Information

Does the individual have a legal guardian? <input type="checkbox"/> No legal guardian. <input type="checkbox"/> Yes, information is below:	
Legal Guardian Last Name_____	First Name_____Phone:_____
Street_____	City_____State_____Zip_____
Primary Physician's Name: _____Phone:_____Fax:_____	
Street_____	City_____State_____Zip_____

Referral Source Signature

I attest that the information submitted herein is true and accurate to the best of my knowledge. I understand that misrepresentation of the individual in the screen is considered Medicaid fraud.		
Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax: