

Date Referral Completed: _____ <small>Month/Day/Year</small>	Screening Agency: _____	Screener Name: _____
Assessing Agency: _____	Assessor Name: _____	Provider #: _____ Worker # _____

**ULTC 100.2 – INITIAL SCREENING AND INTAKE**

**Current Living Situation**

<input type="checkbox"/> Alone	<input type="checkbox"/> With Non-Relatives	<input type="checkbox"/> Pending Nursing Facility Discharge or Admission
<input type="checkbox"/> With Spouse/ Others	<input type="checkbox"/> Alternative Care Facility	<input type="checkbox"/> Hospital Discharge, Date: _____
<input type="checkbox"/> With Non-Spouse Relatives	<input type="checkbox"/> Adult Foster Care	<input type="checkbox"/> DD Residential Program
<input type="checkbox"/> With Parents	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> ICF/MR

**URGENT**

**Applicant Information**

State ID: _____	Primary Language _____	County ID: _____
Last Name: _____	First Name: _____	Middle Initial: _____ SSN: _____
Address: _____	DOB: _____ <small>Month/Day/Year</small>	Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>
City: _____	State: _____	Zip: _____ Phone: _____

**Presenting Problems and Diagnoses**

Comments: \_\_\_\_\_

**Areas of Concern**

<input type="checkbox"/> Bathing	<input type="checkbox"/> Toileting	<input type="checkbox"/> Behaviors	<input type="checkbox"/> Possible Mental Illness
<input type="checkbox"/> Dressing	<input type="checkbox"/> Transferring	<input type="checkbox"/> Memory/Cognition	<input type="checkbox"/> Possible Developmental Disability
<input type="checkbox"/> Eating	<input type="checkbox"/> Mobility		<input type="checkbox"/> Brain Injury

**Potential Community Based Long Term Care Programs**

<input type="checkbox"/> HCBS-Elderly, Blind and Disabled (EBD)	<input type="checkbox"/> HCBS-Persons Living with HIV/AIDS (PLWA)
<input type="checkbox"/> Home Care Allowance (HCA)	<input type="checkbox"/> HCBS-Brain Injury (BI)
<input type="checkbox"/> Private Case Management	<input type="checkbox"/> HCBS-Mentally Ill (MI)
<input type="checkbox"/> Long Term Skilled Home Health	<input type="checkbox"/> HCBS- DD (Comprehensive Services)
<input type="checkbox"/> PACE	<input type="checkbox"/> Consumer Directed Attendant Support(CDAS)
<input type="checkbox"/> HCBS-Children's Extensive Support (CES)	<input type="checkbox"/> Children's HCBS
<input type="checkbox"/> HCBS-Supported Living Services (SLS)	<input type="checkbox"/> HCBS – Children's Autism
<input type="checkbox"/> HCBS-Children's Habitation Residential Program (CHRP)	<input type="checkbox"/> Other Program (specify): _____
<input type="checkbox"/> Medical information page sent to provider.	Provider Name: _____

### Residential Alternatives

- |  |   |
|--|---|
| <input type="checkbox"/> Adult Foster Care         | <input type="checkbox"/> Nursing Facility |
| <input type="checkbox"/> Alternative Care Facility | <input type="checkbox"/> Other:           |
| <input type="checkbox"/> DD Residential Program    | <input type="checkbox"/> ICF/MR           |

### Information and Referral Provided

- |  |  |
|--|--|
| <input type="checkbox"/> Home Health<br><input type="checkbox"/> Vocational Rehabilitation<br><input type="checkbox"/> Community Centered Board<br><input type="checkbox"/> Homeless Shelter<br><input type="checkbox"/> Area Agency on Aging<br><input type="checkbox"/> Child Protection<br><input type="checkbox"/> Hospice | <input type="checkbox"/> Mental Health Services<br><input type="checkbox"/> Veterans Affairs<br><input type="checkbox"/> Adult Protective Services<br><input type="checkbox"/> County Eligibility<br><input type="checkbox"/> Community Food Bank<br><input type="checkbox"/> Other: |
|--|--|

### Contact Information

### Referral Information

Name:		Relationship:		Name:	
Phone #1:		Phone #2:		Phone #:	
Address:				Address:	
City:		State:		City:	
			Zip:		
				Organization/ Relationship:	

### Financial Information

Client Income Source(s)		Spouse Income Source(s)	
Source	Amount	Source	Amount
<input type="checkbox"/> SSA/SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> OAP <input type="checkbox"/> AND/AB	_____	<input type="checkbox"/> SSA/SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> OAP <input type="checkbox"/> AND/AB	_____
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
Gross Monthly Income	\$	Gross Monthly Income	\$
Assets:		Assets:	

### Insurance Information

### Medical Provider Information

<b>Client's Insurance Information</b>  <input type="checkbox"/> VA Benefits <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Private Health Insurance: _____ <input type="checkbox"/> Medicaid <input type="checkbox"/> LTC Medicaid <input type="checkbox"/> Medicaid Pending <input type="checkbox"/> Application in Process <input type="checkbox"/> Application Needed <input type="checkbox"/> Application Mailed Date: _____	<b>Medical Provider Information</b> Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Type of Provider: _____ Contact Person: _____
Comments:	Comments:

Case Assigned to (worker name or number):	Date:
I certify that the accompanying information accurately reflects information given by me or on my behalf on the date specified. I understand that this information is used as a basis for scheduling an assessment and agree to be assessed for all Medicaid Long Term Care benefits administered by the above agency.	Date:
<b>Client or Representative's Signature:</b>	



## Long Term Care Professional Medical Information

Dear Medical Provider:

The following client is participating in a functional needs assessment to determine appropriateness for long term care services. The functional needs assessment is used to determine if the client meets the nursing facility, ICF/MR or hospital level of care. As a part of the functional needs assessment, a licensed medical professional shall complete this form to certify the client's level of functioning and the medical necessity for long term care services.

### Client Information Section:

Last Name: _____	First Name: _____	Middle Initial: _____
Street Address _____	City _____	State <u>CO</u> Zip _____
Date of Birth _____	Telephone _____	Male <input type="checkbox"/> Female <input type="checkbox"/>

### Medical Information Section:

ICD 9 Code	ICD 9 Description	Onset	Medication Name	Dosage	Frequency	Route

Other Services Required for Medical Problems: (oxygen therapy, patient education, monitoring, follow-up care):

Is there a Mental Health Diagnosis?      Yes  No   
 Is there a Traumatic Brain Injury Diagnosis?      Yes  No   
 Diagnosis of dementia must be validated by a neurological exam with documentation by the attending physician.  
 Neurological Exam Date: \_\_\_\_\_

If Hospitalized, Reason: \_\_\_\_\_ Admit Date: \_\_\_\_\_  
 Diet Order: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Prognosis: \_\_\_\_\_

Medical Provider Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of Person Completing this Information \_\_\_\_\_ Title: \_\_\_\_\_  
 Date Completed: \_\_\_\_\_  
 Signature of Licensed Medical Professional Verifying this Information: \_\_\_\_\_  
 Medical Provider Comments: \_\_\_\_\_

### Facility/Case Manager Information

Facility/Case Management Agency: Longterm Care Options  
 Administrator/Case Manager Name (print): \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Administrator/Case Manager Signature: \_\_\_\_\_

9/2007