

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**

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

**URGENT**

<b>Applicant Information</b>		
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: _____

<b>Presenting Problems and Diagnoses</b>
Comments:

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

<b>Potential Community Based Long Term Care Programs</b>	
<input type="checkbox"/> HCBS-Elderly, Blind and Disabled (EBD) <input type="checkbox"/> Home Care Allowance (HCA) <input type="checkbox"/> Private Case Management <input type="checkbox"/> Long Term Skilled Home Health <input type="checkbox"/> PACE <input type="checkbox"/> HCBS-Children’s Extensive Support (CES) <input type="checkbox"/> HCBS-Supported Living Services (SLS) <input type="checkbox"/> HCBS-Children’s Habitation Residential Program (CHRP)	<input type="checkbox"/> HCBS-Persons Living with HIV/AIDS (PLWA) <input type="checkbox"/> HCBS-Brain Injury (BI) <input type="checkbox"/> HCBS-Mentally Ill (MI) <input type="checkbox"/> HCBS- DD (Comprehensive Services) <input type="checkbox"/> Consumer Directed Attendant Support(CDAS) <input type="checkbox"/> Children’s HCBS <input type="checkbox"/> HCBS-Children’s Autism <input type="checkbox"/> Other Program (specify): _____

<input type="checkbox"/> Medical information page sent to provider.	Provider Name: _____
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<b>Residential Alternatives</b>	
<input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Alternative Care Facility	<input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other: _____

<input type="checkbox"/> DD Residential Program				<input type="checkbox"/> ICF/MR					
<b>Information and Referral Provided</b>									
<input type="checkbox"/> Home Health <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Community Centered Board <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Area Agency on Aging <input type="checkbox"/> Child Protection <input type="checkbox"/> Hospice				<input type="checkbox"/> Mental Health Services <input type="checkbox"/> Veterans Affairs <input type="checkbox"/> Adult Protective Services <input type="checkbox"/> County Eligibility <input type="checkbox"/> Community Food Bank <input type="checkbox"/> Other:					
<b>Contact Information</b>				<b>Referral Information</b>					
Name:		Relationship:		Name:					
Phone #1:		Phone #2:		Phone #:					
Address:				Address:					
City:		State:		City:		State:			
				Zip:					
				Organization/Relationship:					
<b>Financial Information</b>									
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:		_____			
<b>Insurance Information</b>				<b>Medical Provider Information</b>					
Client's Insurance Information				Provider Name					
<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: _____				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>									