Colorado Intake Screen Tool

Member Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	Date of Birth:	
Mailing Address:		

Reason for Contact
The discussion guidance below provides general guidance for staff as they initiate/ receive a call. Agencies may customize the language to reflect their operations. • Staff greeting (e.g., Hello. My name is [staff person name] from the [agency name]) • Collect and record caller name • Provide an overview of the agency's functions (e.g., The [agency name] coordinates services through a variety of programs that help individuals perform their day-to-day tasks.) • How may I help you today/what is your reason for calling our agency? • If returning a call from a referral source, also document referral source type (agency/individual), name, and reason for referral
Describe the initial reason for contact as outline above:
Immediate referral to 911? ☐ Yes ☐ No
Is there a potential LTSS Need? ☐ No ☐ Yes, continue with screen
Description of rights modification:
Staff training on proper implementation:

Reason for Contact

Who initiated the call?

☐ Individual seeking services
☐ Parent/Guardian with legal
☐ Parent/Guardian without legal authority
☐ Other family member
☐ Referral – Nursing Facility
☐ Referral – Hospital
☐ SEP
☐ CCB
☐ County DHS, identify county:
☐ Other agency, caller information provided
☐ Other agency, caller information not provided (e.g., fax referral.) Describe agency/referral source:

☐ Other individual:

Caller's Ability to Speak on Behalf of Individual

Is the individual/guardian seeking services aware that the referral has been made? ☐ Yes ☐ No

Does the caller have the individual's permission or legal authority or the guardian's permission to talk with the agency? ☐ Yes ☐ No

Caller Information

First Name:	Last Name:

What is the relationship of the caller to the individual seeking supports?

☐Spouse
☐Child or Child-in-law
☐Parent/Guardian
☐Guardian (Non-Parental)
☐Partner/Significant Other
☐Other Relative:
☐Friend
☐Neighbor
☐Advocate
☐Service/Provider Agency:
☐Other:

Cell Phone Number:	Home Phone Number:
Work Phone Number:	Email:

Preferred method of contact:

☐ Cell Phone
☐ Email
☐ Home Phone
☐ Text Message
☐ Work Phone
☐ Other:

Reason for Contact
Is the individual currently enrolled in an LTSS Program and had an LTSS assessment? ☐ Yes, enrolled in an LTSS Program and had an LTSS Assessment ☐ Yes, had an LTSS Program and had an LTSS assessment but not currently enrolled in an HCBS Program ☐ No ☐ Unknown
Current Insurance: ☐ Medicare ☐ Medicaid ☐ VA Benefits ☐ Private ☐ Other ☐ Unknown

Permission to Complete Screen and Caller Information-Notes/Comments

Determining If Completing Screen Is Appropriate:
Explain the Intake Screen and Assessment process. Provide an overview of the types of questions that will be asked and why they are being asked.
Is the individual/guardian willing/able to answer additional questions and proceed with the remainder of the Screen? ☐ No ☐ Yes, continue with screen ☐ Individual/guardian uncomfortable/unable to complete Eligibility Screen via the telephone, but the assessments is appropriate
Does the individual/guardian have any barriers to completing the Eligibility Screen? ☐ Yes ☐ No
If yes, describe barriers that need to be addressed to accommodate the barriers:
Given the individual's history and the conversation thus far, which action is appropriate? ☐Conduct Eligibility (Continue Eligibility Screen) ☐Conduct Assessment (Skip to Financial Information) ☐Neither

Eligibility Screen ADLs

Eligibility Screen ADLs
Does the individual have any difficult with any of the following ADLs? ☐Bathing ☐Dressing ☐Eating ☐Toileting ☐Transferring ☐Mobility ☐None

Eligibility Screen ADLs

Document additional information related to ADL performance:

Does the individual display/have any memory or cognitive impairments?
☐ No
☐ Yes
☐ Uncertain

If yes or uncertain, describe:

Does the individual display/have any behavior issues?
☐ No
☐ Yes
☐ Uncertain

If yes or uncertain, describe:

Is an assessment justified?
☐ No, and individual does not wish to proceed with Assessment
☐ No, but individual would like to proceed with Assessment
☐ Yes

Does the individual potentially have Intellectual and/or developmental disability (The definition of a developmental disability for the purposes of receiving DD services in Colorado is, "IQ of 70 or below OR Adaptive Behavior of 70 or below with a neurological condition that manifested prior to the individual's 22nd birthday.")
☐ No
☐ Yes

Does the individual have a Developmental Disability Determination or Delay (DD) form on file?
☐ No, interested in IDD Services
☐ No, not interested in IDD Services
☐ Yes
☐ Unknown

Financial Information

Financial Information

Financial information topics to be addressed with individual by Intake Staff:

- Because these services are funded through Health First Colorado (Medicaid), the individual's income and assets must be below certain levels to be eligible for services.
- The exact levels of income and assets vary based upon a number of factors, such as marital status and the individual's employment status.
- There is a financial eligibility process that is separate from the level of care process.
- Health First Colorado (Medicaid) application must be started prior to receiving a level of care assessment.

Financial Information

Does the individual/guardian wish to continue with the Intake Screen based on the financial discussion?
☐ No
☐ Yes

Does the individual receive Supplemental Security Income (SSI)?
☐ No
☐ Yes
☐ Unknown

Has the individual begun the Health First Colorado (Medicaid) application process?
☐ No
☐ Yes
☐ Unknown

Date application submitted:

Risk Trigger Screen

Current Living Situation
☐ Alone, in own home (owned or rented)
☐ With parents/guardians
☐ With spouse
☐ With children
☐ With non-spouse
☐ Alternative Care Facility
☐ Foster Care Home
☐ Kinship Foster Care home
☐ Specialized Group Facility
☐ Nursing Facility
☐ Hospital, discharge date if known
☐ Host Home
☐ Group Home
☐ ICF/IID
☐ Adult Correctional Facility
☐ Homeless
☐ Other

Specify other current living situation:

Based on the conversation thus far, does the individual appear to have a potential risk that may require an expedited functional eligibility determination?
☐ No
☐ Yes

Number of hospitalizations in the past six months:

Number of emergency room visits in the past six months:

Number of calls to 911 in the past six months:

Risk Trigger Screen
Risk Triggers Check if Applicable: ☐ Child and/or Adult-Protective Services have been involved in the individual's life in the past year. ☐ Concerns about abuse, neglect, and/or exploitation. ☐ Individual does not feel safe in home. ☐ Individual does not feel safe in community. ☐ Has had inpatient, psychiatric, or neurobehavioral hospital admission(s) in the past year. ☐ Has residing in or being discharged from a hospital, nursing facility or other facility ☐ Has recently experienced a loss of caregiver support. ☐ Is at risk of becoming homeless. ☐ Has had interaction with the police and/or legal system in the past 6 months ☐ Is a danger to him/herself. ☐ Is a danger to others. ☐ Has experienced a substantial change in health (e.g., new chronic illness, serious accident, etc.) in the past 6 months. ☐ Has been diagnosed with a terminal illness. ☐ Is currently receiving hospice care. ☐ Caregiver at risk. ☐ Based on staff judgement, the individual's health or safety is at risk.
Describe factors above or other factors that present a threat to health and safety:
Based on the above responses, should the individual receive an expedited functional eligibility determination? ☐ No ☐ Yes

Additional Demographic Information

Additional Demographic Information	
Date of Birth:	Assigned Sex at Birth:
Does the member have a Social Security Number? ☐ No ☐ Yes	
Social Security Number:	
If the individual has an existing member record, verify the items in the section below are correct. Primary language of the individual: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Korean ☐ Chinese (Mandarin) ☐ Chinese (Cantonese) ☐ ASL (American Sign Language) ☐ Russian ☐ Other	

Additional Demographic Information
Other primary language:
Does the individual want or need an interpreter (oral or sign language) and/or other communication support? ☐ No ☐ Yes ☐ Unable to determine
If yes, check all that apply below: ☐ Large print ☐ Braille ☐ Materials accessible by electronic reader ☐ Interpreter/communication support staff ☐ Submission of interview questions before assessment ☐ Other
Primary language of the legally recognized representative: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Korean ☐ Chinese (Mandarin) ☐ Chinese (Cantonese) ☐ ASL (American Sign Language) ☐ Russian ☐ Other
Describe other primary language of legally recognized representative:
Does the individual have a Primary Care Provider? ☐ No ☐ Yes
Physician Name:
Physician Telephone:
Physician Fax:
Individual's Marital Status: ☐ Never Married ☐ Married ☐ Civil Union ☐ Partner/Significant other ☐ Widowed ☐ Separated ☐ Divorced ☐ Unknown ☐ Refused ☐ Common Law

Additional Demographic Information
Is the individual of Hispanic, Latino, or Spanish origin? (Check all that apply) ☐ No, not of Hispanic, Latino, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, Other Hispanic, Latino, or Spanish origin ☐ Unknown ☐ Choose not to identify
Would the individual like to declare a race? ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Samoan ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Other Pacific Islander ☐ Some other race ☐ Choose not to identify
Other:
Individual is a Veteran? ☐ No ☐ Yes ☐ Unknown
Individual's current education ☐ Not attending school ☐ Early Intervention ☐ Preschool/Headstart ☐ Elementary ☐ Junior high/Middle school ☐ High school ☐ Post-Secondary ☐ Other:
Name of school:
Type of school: ☐ Public ☐ Private ☐ Charter ☐ Homeschool ☐ Other

Additional Demographic Information
Does the individual require special accommodations or support in school? ☐ No ☐ Yes, Describe
Describe special accommodations or support in school:
Is an IFSP/IEP/504 or other school-based plan in place? ☐ No ☐ Yes

Introduction & Decision Support

Introduction & Decision Support
Individual has legally recognized representative (e.g., POA, DPOA, legal guardian, etc.): ☐ No ☐ Yes
Does this legally recognized representative need/want to be a part of the Assessment? ☐ No ☐ Yes
Name of individual(s) or agency(ies) assisting or authorized in making decisions:
Decision making capacity of person(s) assisting with or legally authorized to make decisions): ☐ Guardian (Non-Parental) ☐ Parent/Guardian ☐ Parent/Non-Guardian ☐ Trustee ☐ Representative Payee ☐ Legally Authorized Representative ☐ Responsible Party ☐ Conservator ☐ Power of Attorney (POA) ☐ Surrogate Decision-maker for health care decisions (DPOA) ☐ Partner of parent ☐ Stepparent ☐ Other relative ☐ Friend ☐ Advocate ☐ Other
Other:
How often does the individual have contact with this individual? ☐ Daily ☐ Weekly ☐ Monthly ☐ Semi-annually ☐ Annually ☐ No contact

Introduction & Decision Support	
Describe:	
Relationship of the Substitute Decision Maker to individual: ☐ Spouse ☐ Child or Child-in-law ☐ Parent /Guardian ☐ Parent/Non-guardian ☐ Guardian (Non-Parental) ☐ Partner/Significant Other ☐ Other Relative ☐ Friend ☐ Neighbor ☐ Advocate ☐ Service/Provider Agency ☐ Other:	
Other:	
Describe other substitute decision maker relationship:	
Cell phone number:	Home phone number:
Work phone number:	Email:
Preferred method of contact: ☐ Email ☐ Mobile phone ☐ Work phone ☐ Home phone ☐ Text Message ☐ Mail	
Address:	
If address in not known, where does substitute decision maker live? ☐ In- State ☐ Out-of-State ☐ Unknown	

Others Individual Wants Present at Assessment and Decision Support
Name:
What is the relationship to the person seeking supports? ☐ Spouse/Guardian ☐ Child or Child-in-law ☐ Parent/Guardian ☐ Parent/Non-guardian ☐ Guardian (Non-Parental) ☐ Partner/Significant Other ☐ Other relative ☐ Friend ☐ Neighbor ☐ Advocate ☐ Service/Provider Agency ☐ Other
Describe other relationship to person seeking supports:
Telephone Number:
Comments:

Others Individual Wants Present at Assessment & Decision Support
Name:
What is the relationship to the person seeking supports? ☐ Spouse/Guardian ☐ Child or Child-in-law ☐ Parent/Guardian ☐ Parent/Non-guardian ☐ Guardian (Non-Parental) ☐ Partner/Significant Other ☐ Other relative ☐ Friend ☐ Neighbor ☐ Advocate ☐ Service/Provider Agency ☐ Other
Describe other relationship to person seeking supports:
Telephone Number:

Others Individual Wants Present at Assessment & Decision Support

Comments:

Introduction & Decision Support Continued

Any other information on accommodation needs, how to best maximize the individual's involvement, and other additional information (e.g., specific directions/apartment codes, beware of dog, etc.):

Indicate the level of involvement the individual will have in making decisions and indicating preferences about service planning.

☐ Individual will be actively engaged in making decisions along with guardian.
☐ Individual will be actively engaged in making decisions along with non-guardian.
☐ Individual will be consulted about preferences by guardian but will have limited involvement in the final decisions.
☐ Individual has significant limitations in his/her capacity to express preferences or engage in decisions.

Opportunities to increase individual's involvement in the assessment and service planning:

Intake Outcomes and Referrals

Introduction to the Assessment
The Assessor should review the following items with the individual:

Purpose of the Assessment is to:

- Collect information to learn more about you, including your need for support and assistance as well as your abilities and strengths. This information will help in choosing services that best fit your situation.
- Confirm what programs and services you are eligible for.
- Allow staff to work with you to develop personally meaningful goals that services and supports can help meet during the Support Planning Process.
- Roles and Responsibilities (check to provide assurance that conversation occurred)
- Individual Roles and Responsibilities-
- Give accurate information to the case manager regarding the individual's ability to complete activities of daily living.
- Assist in promoting the individual's independence.
- Cooperate with the individual's providers and case management agency.
- Notify the case manager of changes in the individual's support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) placements.

Intake Outcomes and Referrals

- Notify the case manager if the individual has not received Home and Community Based Services (HCBS) in accordance with the service plan.
- Notify the case manager of any changes in care needs and/or problems with services.
- Notify the case manager of any changes that may affect Medicaid eligibility.
- Notify the case manager of any critical incidents that the individual may experience or witness.
- Work with the case manager to ensure that responses and goals that are developed reflect the individual's preferences and objectives.

Assessor Roles and Responsibilities

- Coordinate needed services.
- Communicate with service providers regarding service delivery and concerns.
- Review and revise services, as necessary.
- Notify clients regarding any change in services.
- Notify clients when services are denied, suspended, terminated, or reduced.
- Document, report, and resolve client complaints and concerns.
- Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.
- Provide individual with the critical incident definition and explain process of notifying case manager of critical incidents that occur.

Outcome:

☐ Assessment scheduled
☐ Assessment needs to be scheduled
☐ Assessment pending documentation of Health First Colorado (Medicaid) application
☐ DD Determination process started
☐ Expedited functional eligibility determination
☐ Information and referral only - no assessment
☐ Other action

Other action, describe:

Assessor went over roles and responsibilities with individual?

☐ Yes

Referral(s) provided:

☐ None
☐ 911
☐ Additional Support Making Decisions
☐ Advocacy organization/Services
☐ Appropriate Case Management Agency
☐ Crisis services
☐ Child or Adult Protection Services
☐ Colorado Legal Services
☐ Early intervention/Child Find
☐ Housing assistance
☐ Assistance with completing Health First Colorado (Medicaid) application
☐ Mental Health Center/BHO
☐ Regional Accountable Entity (RAE)
☐ Center for Independent Living (CIL)
☐ Area Agency on Aging (AAA)

Intake Outcomes and Referrals
☐ Staff/entity for assignment to Waiting List ☐ Division of Vocational Rehab (DVR) ☐ Guardianship Alliance ☐ Colorado Center for the Blind ☐ Long Term Home Health Agency ☐ Aging and Disability Resource Center (ADRC) ☐ Low-Income Energy Assistance Program (LEAP) ☐ Colorado Works ☐ Food Assistance programs ☐ Legal Services ☐ Other
Describe referral “Other”:
Summary of Contact:

Introduction to the Assessment - Notes/Comments

Introduction to the Assessment - Notes/Comments
Notes/Comments: