Date Referral Completed: _____ (Month/Day/Year)
Screening Agency: _____
Screener Name: _____
Assessing Agency: _____
Assessor Name: _____ Provider #: _____ Worker # _____

ULTC 100.2 – INITIAL SCREENING AND INTAKE

Current Living Situation

☐ Alone	☐ With Non-Relatives	☐ Pending Nursing Facility Discharge or Admission
☐ With Spouse/ Others	☐ Alternative Care Facility	☐ Hospital Discharge, Date:____
☐ With Non-Spouse Relatives	☐ Foster Care	☐ DD Residential Program
☐ With Parents	☐ Nursing Facility	☐ ICF/IID

☐ **URGENT**

Applicant Information

State ID: _____ Primary Language _____ County ID: _____

Last Name: _____ First Name: _____ Middle Initial: _____ SSN: _____

Address: _____ DOB: _____ (Month/Day/Year) Marital Status: S☐M☐D☐W☐

City: _____ State: _____ Zip: _____ Phone: _____

Presenting Problems and Diagnoses

Comments:

Areas of Concern

☐ Bathing	☐ Toileting	☐ Behaviors	☐ Possible Mental Illness
☐ Dressing	☐ Transferring	☐ Memory/Cognition	☐ Possible Developmental Disability
☐ Eating	☐ Mobility		☐ Brain Injury

Potential Community Based Long Term Care Programs

☐ HCBS-Elderly, Blind, and Disabled (EBD)	☐ HCBS-Children with Life Limiting Illness (CLLI)
☐ HCBS-Children's Extensive Support (CES)	☐ HCBS-Spinal Cord Injury (SCI)
☐ HCBS-Supported Living Services (SLS)	☐ Consumer Directed Attendant Support Services (CDASS)
☐ HCBS-Children's Habilitation Residential Program (CHRP)	☐ Home Care Allowance (HCA)
☐ HCBS-Brain Injury (BI)	☐ Private Case Management
☐ HCBS-Community Mental Health Supports (CMHS)	☐ Long Term Skilled Home Health
☐ HCBS-Developmental Disability (DD)	☐ PACE
☐ Children's HCBS (CHCBS)	☐ Other Program (specify): _____

	☐ Medical information page sent to provider.		Provider Name:

Residential Alternatives

☐ Alternative Care Facility	☐ Nursing Facility
☐ DD Residential Program	☐ ICF/IID

☐ Other	☐ Other

Information and Referral Provided

☐ Home Health	☐ Mental Health Services
☐ Vocational Rehabilitation	☐ Veterans Affairs
☐ Community Centered Board	☐ Adult Protective Services
☐ Homeless Shelter	☐ County Eligibility
☐ Area Agency on Aging	☐ Community Food Bank
☐ Child Welfare	☐ Other:
☐ Hospice	

Contact Information

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

Referral Information

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

Financial Information

Client Income Source(s)		Spouse Income Source(s)	
Source	Amount	Source	Amount
☐ SSA/SSDI ☐ SSI ☐ Pension ☐ Employment ☐ OAP ☐ AND/AB		☐ SSA/SSDI ☐ SSI ☐ Pension ☐ Employment ☐ OAP ☐ AND/AB	
☐ Other:		☐ Other:	
Gross Monthly Income	$ 0.00	Gross Monthly Income	$ 0.00
Assets:		Assets:	

Insurance Information

Client's Insurance Information

☐ VA Benefits
☐ Medicare Part A
☐ Medicare Part B
☐ Private Health Insurance: _____
☐ Medicaid
☐ LTC Medicaid
☐ Medicaid Pending
- ☐ Application in Process
- ☐ Application Needed
- ☐ Application Mailed Date: _____

Comments:

Medical Provider Information

Provider Name					
Address:					
City:		State:		Zip:	
Phone:					
Type of Provider					
Contact Person:					

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.

Client or Representative's Signature: Date: