

DEMOGRAPHICS			
Provide the following:	First Name Middle Initial Last Name	Mailing Address City State	Zip Code County Phone
Is this the individual's state of residence?	<input type="checkbox"/> No <Specify state of residence> <input type="checkbox"/> Yes		
Type of identification:	<input type="checkbox"/> Social security number <Provide> <input type="checkbox"/> Other <Provide Passport ID or Temporary resident ID>		
Provide the following:	Date of Birth Marital Status	Gender Race	
Current Location:	<input type="checkbox"/> Community Setting/Home <input type="checkbox"/> Medical Facility Medical Unit <input type="checkbox"/> Medical Facility ER/ED <input type="checkbox"/> Medical Facility Psychiatric Unit <input type="checkbox"/> Psychiatric Facility <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other <Specify>		
Provide the following:	Current Location Address City State	Zip Code Phone	
What has been his/her "typical" living situation over the past year?	<input type="checkbox"/> Home alone <input type="checkbox"/> Home with natural supports/family <input type="checkbox"/> Home with paid supports <input type="checkbox"/> Assisted living <input type="checkbox"/> Nursing facility <input type="checkbox"/> Homeless <input type="checkbox"/> Group home <input type="checkbox"/> Psychiatric facility <input type="checkbox"/> Jail/prison <input type="checkbox"/> ICF/IID (Intermediate care facility for individuals with intellectual disabilities) <input type="checkbox"/> Other <Specify>		
What is the individual's method of payment for nursing facility care?	<input type="checkbox"/> Self Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <Provide Medicare ID> <input type="checkbox"/> Medicaid <Provide Medicaid ID> <input type="checkbox"/> Medicaid Pending <Provide Medicaid ID> <input type="checkbox"/> Dual with Medicaid covering nursing facility <Provide Medicare & Medicaid IDs> <input type="checkbox"/> Dual with Medicare covering nursing facility <Provide Medicare & Medicaid IDs>		
What is the admitting facility?	<input type="checkbox"/> Unknown/not yet identified <input type="checkbox"/> Known facility <input type="checkbox"/> The facility information is not yet offered as a selection <input type="checkbox"/> The facility information in the selection list is not correct		
MENTAL HEALTH DIAGNOSES			
Check any or all of the following mental health conditions that are diagnosed or suspected for this individual now or in the past: <Indicate current or suspected>	<input type="checkbox"/> No mental health diagnosis is known or suspected <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Psychotic/Delusional Disorder <input type="checkbox"/> Bipolar Disorder (I or II) <input type="checkbox"/> Paranoid Disorder/Paranoid Personality Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Depression/Depressive Disorder (including mild or situational) <input type="checkbox"/> Other mental health diagnosis <Specify—do not include dementia>		
SUBSTANCE-RELATED DIAGNOSES			
Does the individual have a substance related disorder (abuse or dependency)? <Indicate last known use>	<input type="checkbox"/> No <input type="checkbox"/> Yes—if yes indicate: <input type="checkbox"/> Alcohol <input type="checkbox"/> Cannabis <input type="checkbox"/> Phencyclidine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Inhalants <input type="checkbox"/> Opioids <input type="checkbox"/> Phencyclidine <input type="checkbox"/> Sedatives/Anxiolytics/Hypnotics <input type="checkbox"/> Amphetamines <input type="checkbox"/> Cocaine <input type="checkbox"/> Other <Specify>		
Is the request for nursing facility care in any way associated with or resulting from the substance related disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
DEMENTIA/NEUROCOGNITIVE DISORDERS			
Does the individual have a diagnosis of dementia/ neurocognitive disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes <If yes, complete rest of section questions>		

Are the deficits due to dementia/ neurocognitive disorder so severe that the individual cannot live in the community because of those deficits?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Due to the dementia/ neurocognitive disorder, does the individual present with any of the following:	1. Significant difficulty communicating? <input type="checkbox"/> No <input type="checkbox"/> Yes 2. Significant difficulty ambulating and/or completing routine motor tasks? <input type="checkbox"/> No <input type="checkbox"/> Yes 3. Significant difficulty recognizing familiar faces? <input type="checkbox"/> No <input type="checkbox"/> Yes	4. Significant short-term memory impairments? <input type="checkbox"/> No <input type="checkbox"/> Yes 5. Significant long-term memory impairments? <input type="checkbox"/> No <input type="checkbox"/> Yes
Is corroborative testing or other information available to verify the presence or progression of the dementia, such as neurological testing, comprehensive mental status exam, or other testing?	<input type="checkbox"/> No <input type="checkbox"/> Yes—if yes indicate: <input type="checkbox"/> Neurological testing <input type="checkbox"/> Mental Status Examination <input type="checkbox"/> CT scans <input type="checkbox"/> Other <Specify>	
INTERPERSONAL BEHAVIORS		
Check any or all of the following interpersonal behaviors or symptoms experienced by this individual recently or in the past: <Indicate when last experienced>	<input type="checkbox"/> There are no known mental health behaviors which affect interpersonal interactions <input type="checkbox"/> Serious difficulty interacting with others <input type="checkbox"/> Altercations, evictions, or unstable employment	<input type="checkbox"/> Excessive isolation from or avoidance of others (such as would occur with a person with severe anxiety, paranoia, depression, or fear of strangers)
CONCENTRATION/TASK COMPLETION		
Check whether any or all of the following task- or concentration-related behaviors or symptoms have occurred for this individual recently or in the past: <indicate when last experienced>	<input type="checkbox"/> There are no known mental health symptoms affecting the individual's ability to think through or complete tasks which s/he should be physically capable of completing	<input type="checkbox"/> Requires assistance thinking through or completing tasks which s/he should be capable of thinking through or completing <input type="checkbox"/> Substantial errors thinking through or completing tasks
MENTAL HEALTH SYMPTOMS		
Check whether any of the following behaviors or symptoms have occurred for this individual recently or in the past: <indicate when last experienced>	<input type="checkbox"/> There are no known recent or current mental health symptoms <input type="checkbox"/> Self-injurious or self-mutilation behaviors <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential to harm) <input type="checkbox"/> Physical threats (potential to harm is unknown) <input type="checkbox"/> Physical threats (no potential to harm) <input type="checkbox"/> Severe appetite disturbance due to depression, sadness, or other mental health condition	<input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things due to depression, sadness, or other mental health condition <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Other major mental health symptoms. These may include symptoms that have emerged or worsened as a result of recent life changes as well as any ongoing symptoms. Describe symptoms.
BEHAVIORAL HEALTH SYMPTOMS		
Has the individual received any of the following mental health services now or in the past? <indicate when last received>	<input type="checkbox"/> No <input type="checkbox"/> Inpatient psychiatric hospitalization <input type="checkbox"/> Mental health partial hospitalization <input type="checkbox"/> Residential treatment/supported housing due to mental health or substance-related disorder	<input type="checkbox"/> Mental health crisis services <input type="checkbox"/> Other intensive mental health services <Specify>
BEHAVIORAL HEALTH IMPACT		
Has there been legal intervention due to mental health symptoms/ behaviors?	<input type="checkbox"/> No <input type="checkbox"/> Yes <indicate when last occurred>	
Has the individual had to move to another setting because of mental health symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes <indicate when last occurred>	

Has the individual ever been homeless?	<input type="checkbox"/> No <input type="checkbox"/> Yes <indicate when last occurred>
Are there other examples where the individual's life has been seriously affected because of mental health symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes <Describe and indicate when last occurred>
MENTAL HEALTH MEDICATIONS	
List any antidepressants, mood stabilizers, antipsychotics, or other mental health medications prescribed currently or anytime within the past six months.	Select from dropdown medication list. Include dosage, frequency, corresponding diagnosis, and a notation of medication discontinuation.
INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES	
Does the individual have a diagnosis of an intellectual disability?	<input type="checkbox"/> No. <See follow-up questions> <input type="checkbox"/> Yes <See follow-up questions>
IF NO: Is the individual suspected to have an intellectual disability that has not been diagnosed?	<input type="checkbox"/> No <input type="checkbox"/> Yes—Identify the presenting evidence below: <ul style="list-style-type: none"> <input type="checkbox"/> History of special education services <input type="checkbox"/> Communication difficulties <input type="checkbox"/> Suspected intellectual disability <input type="checkbox"/> Other <Specify>
IF YES: Did the intellectual disability begin prior to age 18?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Has the individual ever received services from an agency that serves persons with intellectual disabilities?	<input type="checkbox"/> No <input type="checkbox"/> Yes <Provide Facility/Agency name and phone if known>
Does the individual have a developmental condition or diagnosis that affects either/both intellectual and/or adaptive functioning?	<input type="checkbox"/> There is no known or suspected developmental condition or diagnosis that affects intellectual and/or adaptive functioning <input type="checkbox"/> Anoxia at birth <input type="checkbox"/> Arthrogyposis <input type="checkbox"/> Autism spectrum disorder <input type="checkbox"/> Asperger syndrome <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Congenital blindness <input type="checkbox"/> Congenital deafness <input type="checkbox"/> Childhood disintegrative disorder <input type="checkbox"/> Down syndrome <input type="checkbox"/> Encephalitis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Expressive language disorder <input type="checkbox"/> Fetal alcohol syndrome <input type="checkbox"/> Fragile X syndrome <input type="checkbox"/> Fredreich's Ataxia <input type="checkbox"/> Hydrocephaly <input type="checkbox"/> IsoDicentric 15 <input type="checkbox"/> Klippel-Feil syndrome <input type="checkbox"/> Landau-Kleffner syndrome <input type="checkbox"/> Meningitis <input type="checkbox"/> Spina bifida or other neural tube defect <input type="checkbox"/> Pervasive Developmental Disorder <input type="checkbox"/> Phenylketonuria (PKU) <input type="checkbox"/> Polio <input type="checkbox"/> Prader-Willi syndrome <input type="checkbox"/> Rett syndrome <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Traumatic Brain Injury (TBI)/Neurocognitive Disorder due to TBI <input type="checkbox"/> Williams syndrome <input type="checkbox"/> XXY syndrome <input type="checkbox"/> Other <Specify>
IF CONDITION/DIAGNOSIS IS CHOSEN: Did this condition develop prior to age 22?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
IF CONDITION/DIAGNOSIS IS CHOSEN: Due to the condition, does the individual have substantial functional limitations in any of the following areas:	<input type="checkbox"/> There are no substantial functional limitations associated with the condition <input type="checkbox"/> Mobility is impacted due to the condition <input type="checkbox"/> Self Care skills are impacted due to the condition <input type="checkbox"/> Self Direction/Planning is affected due to the condition <input type="checkbox"/> Learning is affected due to the condition <input type="checkbox"/> Understanding/use of language is affected due to the condition <input type="checkbox"/> Ability to live independently is affected due to the condition <input type="checkbox"/> Additional information/explanation <Write in option>

CATEGORICAL DECISIONS (Applies only to persons with known or suspected MI and/or ID/RC)																							
Is the admission occurring because of an emergency?	<input type="checkbox"/> No <input type="checkbox"/> Yes—Check all that apply: <input type="checkbox"/> <Indiana criteria will appear here>																						
<i>IF YES: Submit a copy of one of the following forms.</i>	<Indiana criteria will appear here>																						
Is nursing facility being sought for temporary caregiver respite purposes?	<input type="checkbox"/> No <input type="checkbox"/> Yes—Check all that apply: <input type="checkbox"/> <Indiana criteria will appear here>																						
<i>IF YES: Submit a copy of one of the following forms.</i>	<Indiana criteria will appear here>																						
GUARDIAN/INTERPRETER (Applies only to persons with known or suspected MI and/or ID/RC)																							
Does the individual have a legal guardian?	<input type="checkbox"/> No <input type="checkbox"/> Yes <Provide Guardian name, address, phone, email if available>																						
<i>IF YES: Verify guardian status:</i>	<input type="checkbox"/> Upload verification of guardian status <input type="checkbox"/> I do not have a copy of guardian documents, but I attest that this person is authorized to receive Protected Health Information on this individual's behalf																						
Does the individual have a primary physician?	<input type="checkbox"/> No <input type="checkbox"/> Yes <Provide primary physician name, address, phone if available>																						
What is the individual's primary language/means of communication?	<table border="0"> <tr> <td><input type="checkbox"/> English</td> <td><input type="checkbox"/> Japanese</td> </tr> <tr> <td><input type="checkbox"/> American Sign Language</td> <td><input type="checkbox"/> Korean</td> </tr> <tr> <td><input type="checkbox"/> Arabic/Hindu</td> <td><input type="checkbox"/> Polish</td> </tr> <tr> <td><input type="checkbox"/> Armenian</td> <td><input type="checkbox"/> Portuguese</td> </tr> <tr> <td><input type="checkbox"/> Chinese</td> <td><input type="checkbox"/> Russian</td> </tr> <tr> <td><input type="checkbox"/> Dutch</td> <td><input type="checkbox"/> Spanish</td> </tr> <tr> <td><input type="checkbox"/> French</td> <td><input type="checkbox"/> Tagalog</td> </tr> <tr> <td><input type="checkbox"/> German</td> <td><input type="checkbox"/> Vietnamese</td> </tr> <tr> <td><input type="checkbox"/> Greek</td> <td><input type="checkbox"/> Yiddish</td> </tr> <tr> <td><input type="checkbox"/> Hindu</td> <td><input type="checkbox"/> Other <Specify></td> </tr> <tr> <td><input type="checkbox"/> Italian</td> <td></td> </tr> </table>	<input type="checkbox"/> English	<input type="checkbox"/> Japanese	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Korean	<input type="checkbox"/> Arabic/Hindu	<input type="checkbox"/> Polish	<input type="checkbox"/> Armenian	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Russian	<input type="checkbox"/> Dutch	<input type="checkbox"/> Spanish	<input type="checkbox"/> French	<input type="checkbox"/> Tagalog	<input type="checkbox"/> German	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Greek	<input type="checkbox"/> Yiddish	<input type="checkbox"/> Hindu	<input type="checkbox"/> Other <Specify>	<input type="checkbox"/> Italian	
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<i>IF SELECTION OTHER THAN ENGLISH: Is an interpreter needed?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <Note how interpreter service should be obtained>																						
SUBMITTER ATTESTATION /SIGNATURE																							
<i>Automatically imports submitter name, facility, street, city, zip, fax, phone, and email information from login. Gives opportunity to provide any additional contacts to reach if questions arise and/or additional phone numbers.</i>																							
<input type="checkbox"/> 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 this screen is considered Medicaid fraud.																							