

Name: _____

Social Security #: _____

**STATE OF TENNESSEE
DIVISION OF MENTAL RETARDATION
INTAKE FORM**

DATE: _____ STAFF PERSON COMPLETING FORM: _____

INITIAL CONTACT BY: Telephone Fax Email Walk-in Mail

I. Information about the individual needing services:

Last Name:	First Name:	Middle Initial:
Address (Street, City, State, Zip)		
Special Mailing Accommodations/Instructions:		
County:	Date of Birth:	Age:
Phone Numbers: Home:	Work:	Cell:
Social Security Number: - -	Is there a diagnosis of Mental Retardation Prior to age 18? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Age 0-4 with high probability of MR <input type="checkbox"/> Age 0-5, No diagnosis	
	If No: Indicate other programs referred to:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/ Pacific Islander <input type="checkbox"/> Other, specify: _____	
Financially Medicaid Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Has Applied, Waiting on Response <input type="checkbox"/> Has Applied & Been Denied	Financial Resources: <input type="checkbox"/> SSI <input type="checkbox"/> SSA <input type="checkbox"/> Veterans <input type="checkbox"/> Wages _____ <input type="checkbox"/> Other, specify: _____	

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II. Information about the primary contact person (e.g., parent, guardian/ conservator, family member, friend):

Last Name:		First Name:	
Address (if different from individuals) Street, City, State, Zip):			
Special Mailing Accommodations/Instructions			
Phone Numbers: Home:		Work:	Cell:
Relationship to individual interested in services: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Conservator/Guardian <input type="checkbox"/> Other Relative: _____ <input type="checkbox"/> Other, specify: _____			
* If Conservator/Guardian, Notify the caller that a copy of their Legal Documentation of this is needed.			

III. Records: To be completed by Case Management Staff

Individual Has an existing record: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Are the records attached <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Location:
Is the person currently receiving services: <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, list the type of services, where services are received and the provider of services: _____

IV. Criteria for Assessment of Category of Need:

<p>Crisis: The person needs services immediately for the following reasons:</p> <ul style="list-style-type: none">▪ Homelessness of the Individual<ul style="list-style-type: none">- The individual is currently homeless; or- The individual will be homeless within 30 days; or▪ Death, incapacitation, or loss of the primary caregiver and lack of an alternate primary caregiver:<ul style="list-style-type: none">- The primary caretaker died; or- The primary caretaker became mentally or physically incapacitated (permanently or expected to last more than 30 days); or- The primary caregiver serves as the primary caregiver for one or more other individuals with serious mental, physical, or developmental disabilities and is unable to provide an acceptable level of care for the enrollee; or- The primary caregiver must be employed to provide the sole or primary income for the support of the family; or▪ Serious and imminent danger of harm to self or to others by the individual;<ul style="list-style-type: none">- The individual's current pattern of behavior poses a serious and imminent danger of self-harm

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which cannot be reasonably and adequately managed by the caregiver; or

- The individual’s current pattern of behavior poses a serious and imminent danger of harm to others which cannot be reasonably and adequately managed by the primary caregiver.

Urgent: The person is at risk for meeting the criteria for “crisis” or meets one or more of the following criteria:

- Aging or failing health of caregiver and no alternate available to provide supports;
- Living situation presents a significant risk of abuse or neglect;
Increasing behavioral risk to self or others;
- Stability of current living situation is severely threatened due to extensive support needs or family catastrophe;
- Discharge from other service system (e.g., DCS, MHI, Forensics) is imminent

Active: The person or the person’s family or conservator is requesting access to services as of now but does not have intensive needs which meet the urgent or crisis criteria above.

Deferred: The person or the person’s family or conservator is requesting access to services in the future (12 months or more).

Preliminary Identification of Category of Need: To be completed by Case Management Staff

<input type="checkbox"/> Crisis	<input type="checkbox"/> Non –Crisis
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V. Assignments: To be completed by Case Management Staff

Case Manager:	Date Assigned:
If assigned case manager is not available on date assigned for Crisis determination, forward to immediate supervisor.	

VI. Initial Checklist: To be completed by Case Management Staff

Item	Crisis		Non-Crisis	
	Date Due	Date Completed	Date Due	Date Completed
Call Back	Within one business day of intake call		Within 14 calendar days of intake call	
Information Packet Mailed	NA – Case manager will deliver the packet at face to face visit.		Within 3 business days of intake call	
Call to Schedule Face to Face Visit	Within one business day of intake call		Within 14 calendar days of intake call	
Face to Face Due	Within 3 business days of intake call		Within 30 calendar days of intake call	
Letter of Notification for Category of Need	Within 2 business days of completing packet		Within 5 business days of completing packet	

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<p>Explanations Completed during Face to Face Visit</p> <input type="checkbox"/> The Waivers and its services <input type="checkbox"/> State Interim services <input type="checkbox"/> Consumer directed services <input type="checkbox"/> Self- Directed services <input type="checkbox"/> Case Management	<p>Additional Items completed/requested during Face to Face Visit:</p> <input type="checkbox"/> HIPAA <input type="checkbox"/> Voter Registration <input type="checkbox"/> Release of Information (s) <input type="checkbox"/> Family Handbook, Family Support Program <input type="checkbox"/> Freedom of Choice Form <input type="checkbox"/> Other Community Resources as deemed necessary <input type="checkbox"/> ICAP Scheduled <input type="checkbox"/> ICAP Completed <input type="checkbox"/> Privacy Notice <input type="checkbox"/> Individual Rights <input type="checkbox"/> Conservatorship Documentation <input type="checkbox"/> Physical <input type="checkbox"/> Psychological
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VII. Current Living Situation

Where does the Individual live?		
<input type="checkbox"/> Parent's Home	<input type="checkbox"/> ICF/MR	<input type="checkbox"/> Mental Health Institute
<input type="checkbox"/> Other Relative's home: _____	<input type="checkbox"/> Out of State	<input type="checkbox"/> Other Psychiatric Hospital
<input type="checkbox"/> Own Home	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Child in Residential Placement
	<input type="checkbox"/> DCS Foster Home	<input type="checkbox"/> Other, specify: _____

Who is the Primary Caregiver (who provides direct daily care on a regular ongoing basis)? Complete the following for each person named.			
Name:			
Relationship:	<input type="checkbox"/> Parent <input type="checkbox"/> Conservator/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other, specify:	<input type="checkbox"/> Parent <input type="checkbox"/> Conservator/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other, specify:	<input type="checkbox"/> Parent <input type="checkbox"/> Conservator/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other, specify:
Age Range:	<input type="checkbox"/> 40 or under <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-60 <input type="checkbox"/> 61-70 <input type="checkbox"/> 71 +	<input type="checkbox"/> 40 or under <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-60 <input type="checkbox"/> 61-70 <input type="checkbox"/> 71 +	<input type="checkbox"/> 40 or under <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-60 <input type="checkbox"/> 61-70 <input type="checkbox"/> 71 +
Work Status:	<input type="checkbox"/> One Caregiver, works outside of the home <input type="checkbox"/> Two caregivers, both work outside the home	<input type="checkbox"/> One Caregiver, works outside of the home <input type="checkbox"/> Two caregivers, both work outside the home	<input type="checkbox"/> One Caregiver, works outside of the home <input type="checkbox"/> Two caregivers, both work outside the home
Work Schedule:			
Overall Health:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

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Is there anything right now that makes it difficult for the caregiver to serve in this role? Yes No
If yes, please describe:

VIII. Category of Need Determination: To be completed by Case Management Staff

Crisis:	<input type="checkbox"/>	Homelessness
	<input type="checkbox"/>	Death or incapacitation of all available caregivers
	<input type="checkbox"/>	Primary caregiver is sole or primary income for family
	<input type="checkbox"/>	Immediate danger to self or others
Urgent:	<input type="checkbox"/>	Aging/Failing health of caregiver
	<input type="checkbox"/>	Living situation has significant risk of abuse/neglect
	<input type="checkbox"/>	Increasing risk to self or others
	<input type="checkbox"/>	Stability of home is severely threatened due to extensive support needs or family catastrophe
	<input type="checkbox"/>	Discharge from other service system (DCS, MHI)
Active:	<input type="checkbox"/>	Requests services now, but does not have intensive needs
Deferred:	<input type="checkbox"/>	Requests access to services in the future (12 months or more)

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IX. Eligibility and Services Determination

Individual Service Needs			
Please refer to <i>THE HANDBOOK</i> for more details about the services listed below.			
Service	Need	When	Where (County)
Personal Assistant – a service that helps people with everyday activities and skills in the home or community.			
Day Habilitation – a day service that helps people learn daily living, social, communication & other skills			
Community Participation – a day service to help people be a part of their communities.			
Supported Employment – a service to help people find and keep a job.			
Respite – service for people living at home, allowing the family to take a break or to meet emergency needs.			
Transportation – public or private transportation to and from services			
Environmental Accessibility – minor changes to a home to create easier access & use of the home			
Specialized Medical Supplies – Supplies that are needed due to the person’s disability or health status not covered by other insurance or programs.			
Personal Emergency Response System - a way for people who live alone, to call for emergency assistance			
Residential Services – services to help the person live in a home other than with their family			
Health Care Supplies – supplies that are needed due to the person’s disability or health status not covered by other insurance or programs			
Orientation & Mobility Training – services to help someone with blindness access their home & community independently			
Nutrition – services to assist the person in developing & maintaining good nutritional health			
Speech - services to assist the person in expanding communication skills and address swallowing concerns. Must be prescribed by a physician			
Occupational Therapy – services to assist a person in functioning across settings. Fine Motor Skills. Must be prescribed by a physician			
Physical Therapy – services to assist the person in moving around in various settings. Gross Motor Skills. Must be prescribed by a physician.			
Behavior Services – services to help the person live and interact within their community more positively.			
Intermittent Nursing – skilled nursing services in the home. Must be prescribed by physician.			
Services Exceed \$30,000 annually			
Ongoing Nursing – not covered by Tenn Care			
Ongoing Behavior Supports			
Total estimated Cost:			

Signature of Person Needing Services or Legal Representative:	Date:
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*this signature indicates understanding of information listed in the Individual Service Needs table only.

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Individual's current needs indicate he/she could receive services through: To be completed by Case Management Staff

<input type="checkbox"/> Consumer Directed Supports	<input type="checkbox"/> Waiting List for SD Waiver
<input type="checkbox"/> State Interim Services	<input type="checkbox"/> HCBS Waiver through Crisis
<input type="checkbox"/> Self Directed Services through SD Waiver	<input type="checkbox"/> Waiting List for HCBS Waiver

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XI. Privacy Notice

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF MENTAL RETARDATION SERVICES
ACKNOWLEDGEMENT OF RECEIPT OF
DMRS PRIVACY NOTICE**

I have been given a copy of the Division of Mental Retardation Services' Privacy Notice that describes how my health information is used, stored, and shared. I understand that DMRS has the right to change this notice at any time and that I will be notified.

(Printed Name of Individual Receiving the Notice)

(Signature of Individual or Legal Representative)

(Date)

A copy of this signed form will be kept in the Individual's Record.

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XII. Individual Rights

It is important for every person to know his or her rights. These are your rights if you receive services in the Home and Community based Medicaid Waiver, or the Self-Determination Medicaid Waiver, or if you are seeking services from a DMRS Regional Office.

I have been given a copy of my individual rights and this information has been explained to me by the case manager.

I understand that a copy of this signed form will be kept in my record.

Signature of Person applying for services or Legal Representative

Date

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XIII. PAE Process: To be completed by Case Management Staff

Physical Date: _____	Psychological Evaluation Date: _____	
Full Scale IQ Score: _____	Adaptive Behavior Level: _____	MR Level: _____
PAE form completed: _____	PAE sent to TennCare: _____	
PAE <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date: _____	
Notifications: <input type="checkbox"/> Individual & Legal Representative	<input type="checkbox"/> Agency (specify): _____	

Signature of person completing form **Title** **Date**

The information that has been provided in this Application for Services is true and accurate. I have been informed about the steps that will be taken next by the Regional Office to process this Application. I understand that being included on the waiting list for services does not guarantee eligibility for Medicaid funded services. I have also been informed that I may contact the Regional Office at any time to update this information should circumstances or needs change.

Signature of person needing services **Date**

Signature of Legal Representative **Relationship** **Date**