FUNCTIONAL ELIGIBILITY SCREEN FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

The Functional Screen is voluntary for consumers. The person being screened should consent to completion of the functional screen and its submission to DHS for screen development and aggregate data research. No screen should be completed without the person's signed informed consent. However, where the screen is the tool for determining need for services, the consumer needs to know that refusal to participate in the screening process could affect their eligibility for services. All information will be confidential within the Department and the screening agency.

BASIC INFORMATION

Basic Screen Information

Name - Screener	Name – Screening Agency
Date of Referral (mm/dd/yyyy)	Screen Type (Check only one box) ☐ 01 Initial Screen ☐ 02 Annual Screen ☐ 03 Screen due to change in condition/situation (or by request)

Applicant Information

Title	Name – Applicant (First)	(Middle)	(Last)
Gender ☐ Male ☐ Female	Social Security Number (###-##-####)	Date of Birth (mm/dd/yyyy)	

Applicant's Contact Information

Address

City	State	Zip Code	Phone – Home ( ) -

Telephone – Work ( ) -	Cell Phone ( ) -	County/Tribe of Residence	County/Tribe of Responsibility

Directions to Residence

TRANSFER INFORMATION

To be completed after eligibility determination and enrollment counseling and after applicant enrolls in a program.

Date of Referral to Service Agency (mm/dd/yyyy)	Name – Service Agency

REFERRAL SOURCE

Referral Source (Check only one box)

Informal Sources
- ☐ Self
- ☐ Family/Significant Other
- ☐ Friend/Neighbor/Advocate

Psychiatric/Mental Health Providers
- ☐ Hospital Psychiatric Inpatient
- ☐ Mental Health Institution (e.g., Mendota) or other IMD
- ☐ Clinic, Outpatient, or Day Treatment
- ☐ Residential

General Health Care Provider
- ☐ Inpatient
- ☐ Outpatient
- ☐ Nursing Home

AODA Provider
- ☐ Inpatient (includes detoxification)
- ☐ Residential Service
- ☐ Outpatient Service
- ☐ Day Treatment

Criminal Justice System
- ☐ Jail or Prison
- ☐ Probation or Parole
- ☐ Police/Law Enforcement

Other Human Services Systems
- ☐ Family Care or County Long-Term Support Program
- ☐ Aging and Disability Resource Center
- ☐ Private Service Provider
- ☐ Child Welfare or Adult Protective Services

☐ Other—Please specify: _____

☐ No Referral (e.g., annual rescreen, change in condition)

Primary Source for Screen Information (Check only one box)

- ☐ Individual
- ☐ Guardian
- ☐ Spouse/Significant Other
- ☐ Parent
- ☐ Child
- ☐ Other family member—Specify: _____
- ☐ Advocate
- ☐ Other—Specify: _____
- ☐ Case Manager
- ☐ Hospital Staff
- ☐ Nursing Home Staff
- ☐ ICF-MR/State DD Center Staff
- ☐ Residential Provider (e.g., group home, AFH)
- ☐ Home Health, Personal Care, or Supportive Home Care Staff
- ☐ Probation/Parole Officer

Where Screen Interview was Conducted (Check only one box)

- ☐ Person's Current Residence
- ☐ Temporary Residence (non-institutional)
- ☐ Nursing Home
- ☐ Other—Please specify: _____
- ☐ General Hospital
- ☐ Psychiatric Hospital or other IMD
- ☐ Agency Office, Resource Center

DEMOGRAPHICS

Medical Insurance [Check all boxes that apply and fill in information to the right of selected option(s)]

☐ Medicare Policy Number: _____

☐ Part A ☐ Part B ☐ Medicare Managed Care

☐ Medicaid Policy Number: _____

☐ MA Managed Care or HMO

☐ Private Insurance [includes employer-sponsored (job benefit) insurance]

☐ VA Benefits Policy Number: _____

☐ Railroad Retirement Policy Number: _____

☐ No medical insurance at this time

Ethnicity [Optional]

Is participant Hispanic or Latino?

☐ Yes

☐ No

Race [Optional] (Check all boxes that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

If an interpreter is requested, select language below

☐ American Sign Language
☐ Spanish
☐ Vietnamese
☐ Other—Specify: _____
☐ Hmong
☐ Russian
☐ A Native American Language

Is the person under court orders (or negotiated settlement) for treatment?

☐ Yes
☐ No

CONTACT INFORMATION

Legal Guardian or Parent of a Minor Responsible for Making Decisions about Medical Care

Name (First)	(Middle)	(Last)
Address		
Phone – Home ( ) -	Phone – Work ( ) -	Cell Phone ( ) -
City	State	Zip Code

Best time to contact and/or comments:

Activated Power of Attorney for Health Care Responsible for Making Decisions about Medical Care

Name (First)	(Middle)	(Last)
Address		
Phone – Home ( ) -	Phone – Work ( ) -	Cell Phone ( ) -
City	State	Zip Code

Best time to contact and/or comments:

Other Relevant Contact

Relationship to Applicant:

☐ Adult Child ☐ Parent/Step-Parent ☐ Case Manager
☐ Ex-Spouse ☐ Sibling ☐ Representative Payee
☐ Spouse ☐ Other Family Member
☐ Other—Specify: _____

Name (First)	(Middle)	(Last)
Address		
Phone – Home ( ) -	Phone – Work ( ) -	Cell Phone ( ) -
City	State	Zip Code

Best time to contact and/or comments:

LIVING SITUATION

Current Residence (Check only one box)

Home or Apartment

- ☐ Own home or apartment (alone or with someone)
- ☐ Someone else's home or apartment
- ☐ Residential Care Apartment Complex (RCAC) or other supported apartment program

Group Residential Setting

- ☐ Adult Family Home
- ☐ Group Home – CBRF (Community-Based Residential Facility, Child Caring Institution)
- ☐ Transitional Housing – Mental Health, AODA, or Corrections System

Health Care Facility/Institution

- ☐ Nursing Home (Includes rehabilitation facility if licensed as a nursing home)
- ☐ ICF-MR/FDD/DD Center/State institution for people with developmental disabilities
- ☐ Mental Health Institute/State psychiatric institution (e.g., Mendota)
- ☐ Other IMD

☐ No permanent residence (is homeless, in a shelter, or temporarily in a motel or with friends)

☐ Other (includes jail)—Specify: _____

Prefers to Live (Check only one box)

Home or Apartment

- ☐ Own home or apartment (alone or with someone)
- ☐ Someone else's home or apartment
- ☐ Residential Care Apartment Complex (RCAC) or other supported apartment program

Group Residential Setting

- ☐ Adult Family Home
- ☐ Group Home – CBRF (Community-Based Residential Facility, Child Caring Institution)
- ☐ Transitional Housing – Mental Health, AODA, or Corrections System

Health Care Facility/Institution

- ☐ Nursing Home (Includes rehabilitation facility if licensed as a nursing home)
- ☐ ICF-MR/FDD/DD Center/State institution for people with developmental disabilities
- ☐ Mental Health Institute/State psychiatric institution (e.g., Mendota)
- ☐ Other IMD

☐ No permanent residence (is homeless, in a shelter, or temporarily in a motel or with friends)

☐ Unable to determine person's preference for living arrangement

☐ Other (includes jail)—Specify: _____

VOCATIONAL INFORMATION

Current Work Status (Check only one box)

- ☐ Full-time competitive employment
- ☐ Part-time competitive employment
- ☐ Sheltered workshop, pre-voc
- ☐ Retired
- ☐ Not employed
- ☐ Unpaid work: homemaker, caregiver, volunteer, or student

Interest in a Job (Check only one box)

- ☐ Interested in having a job
- ☐ Interested in having a **new** job
- ☐ Not interested in having a job or a new job
- ☐ Wants to work, but is afraid of losing MA and SSA benefits

Needs assistance to find/apply for work:

- ☐ NA
- ☐ Independent
- ☐ Needs Assistance

Needs assistance to work—needs assistance to function at a job. Includes showing up on time, dressing appropriately, performing expected tasks, and performing in cooperation with others (does not include transportation).

- ☐ NA
- ☐ Independent
- ☐ Less than monthly
- ☐ One to four times a month
- ☐ More than one time per week

Needs assistance with schooling—needs assistance to find and/or apply for schooling or to function at school. Includes registering for school, scheduling classes, showing up on time, and performing in cooperation with others (does not include educational tutoring).

- ☐ NA
- ☐ Independent
- ☐ Less than monthly
- ☐ One to four times a month
- ☐ More than one time per week

COMMUNITY LIVING SKILLS INVENTORY

Check box that reflects the needs of applicant as it pertains to needing assistance from another person, i.e., is unable to function successfully in these areas without assistance from others **within the past six months**. See Screen Instructions. (**"Assistance"** includes monitoring, supervision, reminding, coaching, or direct service.)

Benefits/Resource Management—Needs assistance to plan for, access, and navigate benefits (e.g., Section 8, SSI, SSDI, Medicaid, Medicare, insurance, etc.). Does NOT include money management, which is captured elsewhere.

☐ No ☐ Yes

Basic Safety—Needs help from others because is unable to recognize immediately dangerous situations or to respond in an emergency. Does not include high-risk behaviors commonly engaged in by the public (such as unsafe sex, drinking and driving, poor health habits).

☐ No ☐ Yes

Social or Interpersonal Skills—Needs assistance to effectively interact with others to have adult social relationships, and to carry out adult social or recreational activities according to personal preferences.

☐ No ☐ Yes

Home Hazards—Needs assistance to maintain basic living environment to avoid disease hazards, fire hazards (e.g., hoarding), and/or odors noticeable from outside.

☐ Independent ☐ One to four times a month
☐ Less than monthly ☐ More than one time per week

Money Management—Needs assistance to manage finances for basic necessities (food, clothing, shelter). Includes needing assistance to handle money, pay bills, and to budget

☐ Independent ☐ One to four times a month
☐ Less than monthly ☐ More than one time per week

Basic Nutrition—Needs assistance to maintain eating schedule, obtain groceries and/or to prepare or obtain simple meals (and avoid spoiled foods). Does NOT include transportation, which is captured elsewhere.

☐ Independent ☐ One to four times a month
☐ Less than monthly ☐ More than one time per week

General Health Maintenance—Needs assistance to care for own health and to recognize symptoms. Includes managing health conditions (e.g., diabetes, hypertension) and making and keeping medical appointments. Does NOT include medication management, which is captured elsewhere.

☐ Independent ☐ One to four times a month
☐ Less than monthly ☐ More than one time per week

Managing Psychiatric Symptoms—Needs assistance (by a person other than a physician) to manage mental health symptoms (e.g., hallucinations, delusions, mania, thought disorders, etc.). Does NOT include AODA or general health symptoms.

☐ Independent ☐ One to four times a month
☐ Less than monthly ☐ More than one time per week

Hygiene and Grooming—Needs assistance to maintain basic hygiene and grooming.

☐ Independent ☐ One to four times a month
☐ Less than monthly ☐ More than one time per week

Taking Medications—Needs assistance with taking medications, medication administration and assisting with self-administration, which includes setup, reminders, cueing, and/or observation to ensure person takes medication. Includes all prescribed meds—psychotropics and others.

☐ Needs someone to administer regular **IM** (intramuscular) injections

Assistance needed with other prescribed meds:

☐ NA (has no medications) ☐ One to four days a month
☐ Independent ☐ Two to six days per week
☐ Less than monthly ☐ One or more times daily

Monitoring Medication Effects—Needs assistance monitoring effects and side effects of prescribed medications. This includes recognizing effects and noticeable side effects of prescribed medications, reporting medication effects or new problems to a prescribing professional, and/or following any medication or dose changes recommended by the prescriber. Includes all prescribed meds—psychotropics and others.

- ☐ NA (has no medications)
- ☐ Independent (can notice and report problems to prescriber or others as needed)
- ☐ Less than monthly
- ☐ One to four days a month
- ☐ Two to six days per week
- ☐ One or more times daily

Transportation—Needs assistance to arrange for transportation, use public transportation, or drive and maintain a vehicle.

- ☐ Person drives
- ☐ Person drives but there are serious safety concerns
- ☐ Person cannot drive **due to physical, psychiatric, or cognitive impairment**. Includes no driver's license due to medical problems (e.g., seizures, poor vision)
- ☐ Person does not drive **due to other reasons (e.g., lost license, has no car**)

Physical Assistance—Needs assistance to physically accomplish the following tasks (check all that apply):

- ☐ Independent
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Mobility in home
- ☐ Transferring

CRISIS AND SITUATIONAL FACTORS

Check all that apply or have applied

Use of emergency rooms (not just for E.D.), crisis intervention (not just phone), or withdrawal management

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year	Frequency:	☐ 1-3 times	☐ 4 or more times
☐ 13 months to 3 years ago	Frequency:	☐ 1-3 times	☐ 4 or more times

Psychiatric inpatient stays (voluntary or involuntary)

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year	Frequency:	☐ 1-3 times	☐ 4 or more times
☐ 13 months to 3 years ago	Frequency:	☐ 1-3 times	☐ 4 or more times

Chapter 51 Emergency Detention(s)

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year	Frequency:	☐ 1-3 times	☐ 4 or more times
☐ 13 months to 3 years ago	Frequency:	☐ 1-3 times	☐ 4 or more times

Physical Aggression (e.g., hitting/assaulting others, damage to property, fire setting). Includes nonconsensual sexual aggression

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year	Frequency:	☐ 1-3 times	☐ 4 or more times
☐ 13 months to 3 years ago	Frequency:	☐ 1-3 times	☐ 4 or more times

☐ Physical aggress has resulted in the injured person being hospitalized (does not include ER visit only)

Involvement with the corrections system (e.g., OWI/DUI, arrests, or jail)

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year	Frequency:	☐ 1-3 times	☐ 4 or more times
☐ 13 months to 3 years ago	Frequency:	☐ 1-3 times	☐ 4 or more times

Suicide Attempts

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year	Frequency:	☐ 1-3 times	☐ 4 or more times
☐ 13 months to 3 years ago	Frequency:	☐ 1-3 times	☐ 4 or more times

☐ Has had suicidal ideation with a feasible plan within the past two months

RISK FACTORS

Check all that apply or have applied

Self-injurious behaviors (e.g., cutting, burning, pica, polydipsia, head banging). Does NOT include suicide attempts

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year ☐ 13 months to 3 years ago

Outcomes of Substance Use (choose only one)

☐ No or low risk evident in past 12 months (include persons in Sustained Remission – no symptoms, except for craving, for more than 12 months)

☐ In past 12 months, substance use has involved risks but it is not clear that negative consequences have occurred

☐ In past 12 months, person has exhibited a problematic pattern of use leading to clinically significant impairment or distress.

Answer the following five questions if one of the last two options directly above were chosen (Check only one box):	In the last 30 days	Not in the last 30 days, but yes in last year	Not applicable
Used alcohol or drugs weekly or more often	☐	☐	☐
Spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick).	☐	☐	☐
Kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting into trouble with other people.	☐	☐	☐
Use of alcohol or drugs caused applicant to give up, reduce or have problems at important activities at work, school, home or social events.	☐	☐	☐
Had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or used any alcohol or drugs to stop being sick or avoid withdrawal problems.	☐	☐	☐

Have you received treatment, counseling, medication, case management or aftercare for your uses of alcohol or any other drug? Please do not include any emergency room visits, withdrawal management, and support group meetings.

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year ☐ 13 months to 3 years ago

Have you attended one or more support group meetings or received support from a peer specialist or recovery coach for your alcohol or other drug use? (e.g., AA, NA, Celebrate Recovery, SMART Recovery, etc.)

☐ Unknown ☐ No ☐ Yes—Check all time periods that apply:

☐ Within past year ☐ 13 months to 3 years ago

We know that many people have experienced physical, emotional, or sexual abuse, or neglect as an adult or in childhood. Would you say that applicant has?

☐ Unknown ☐ No ☐ Yes

Housing Instability

☐ Unknown ☐ No ☐ Yes—Check all that apply to indicate type of housing instability within the past 12 months:

☐ Currently homeless (on the street or not permanent address)

☐ Homeless less than half the time in the past year

☐ Homeless more than half the time in the past year

☐ Has been evicted two or more times in the past year

Intensity of Treatment or Functional Severity

There have been consistent and extensive efforts to treat this person for at least a year, or the person has had a serious sudden onset of dysfunction requiring services beyond basic outpatient services, **and** the person is dangerous to self or to others. ☐ Yes ☐ No

Interdivisional Agreement 1.67

The person resided in a nursing home or received HCBW services and was referred through Interdivisional Agreement 1.67 in accordance with s. 46.27(6r)(b)(3). ☐ Yes ☐ No

Current COP Level 3 Funding

Is the person currently receiving COP Level 3 funding for serious and persistent mental illness? ☐ Yes ☐ No

MENTAL HEALTH AND AODA DIAGNOSES

Mark all active diagnoses using the most recent assessment. Diagnoses must be obtained through a health care provider or medical record.

☐ No current diagnoses

Anxiety, Obsessive-Compulsive and Related Disorders
- ☐ F40.xx Agoraphobia
- ☐ F45.22 Body Dysmorphic Disorder
- ☐ F41.1 Generalized Anxiety Disorder
- ☐ F42.xx Obsessive-Compulsive Disorder & Related Disorder
- ☐ F41.8, F41.9 Other Specified/Unspecified Anxiety Disorder
- ☐ F41.0 Panic Disorder
- ☐ F40.1x Social Anxiety Disorder (Social Phobia)

Bipolar and Related-Disorders
- ☐ F31.xx Bipolar Disorder I or II
- ☐ F34.0 Cyclothymic Disorder
- ☐ F39 Unspecified Mood Disorder

Depressive Disorders
- ☐ F33.xx Major Depressive Disorder - Recurrent
- ☐ F32.xx Major Depressive Disorder - Single Episode
- ☐ F34.1 Persistent Depressive Disorder (Dysthymic Disorder)

Dissociative Disorders
- ☐ F44.81 Dissociative Identity Disorder
- ☐ F44.89, F44.9 Other Specified/Unspecified Dissociative Disorder

Feeding and Eating Disorders
- ☐ F50.0x Anorexia Nervosa
- ☐ F50.2 Bulimia Nervosa
- ☐ F50.9 Unspecified Feeding or Eating Disorder

Impulse Disorders
- ☐ F63.81 Intermittent Explosive Disorder

Personality Disorders
- ☐ F60.2 Antisocial Personality Disorder
- ☐ F60.6 Avoidant Personality Disorder
- ☐ F60.3 Borderline Personality Disorder
- ☐ F60.7 Dependent Personality Disorder
- ☐ F60.4 Histrionic Personality Disorder
- ☐ F60.81 Narcissistic Personality Disorder
- ☐ F60.5 Obsessive-Compulsive Personality Disorder
- ☐ F60.0 Paranoid Personality Disorder
- ☐ F60.1 Schizoid Personality Disorder
- ☐ F21 Schizotypal Personality Disorder
- ☐ F60.89, F60.9 Other Specified/Unspecified Personality Disorder

Schizophrenia Spectrum & Other Psychotic Disorders
- ☐ F22 Delusional Disorder
- ☐ F25.x Schizoaffective Disorder
- ☐ F20.xx Schizophrenia
- ☐ F20.81 Schizophreniform Disorder
- ☐ F28, F29 Other Specified/Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Somatoform Symptom and Related Disorders
- ☐ F44.4-F44.7 Functional Neurological Symptom Disorder (Conversion Disorder)
- ☐ F45.21 Illness Anxiety Disorder
- ☐ F45.1, F45.8, F45.9 Somatic Symptom Disorder

Substance-Related Disorders
- ☐ F10.1x Alcohol Use Disorder, Mild
- ☐ F10.2x Alcohol Use Disorder, Moderate/Severe
- ☐ F15.1x Amphetamine Use, Mild
- ☐ F15.2x Amphetamine Use, Moderate/Severe
- ☐ F14.1x Cannabis Use Disorder, Mild
- ☐ F12.2x Cannabis Use Disorder, Moderate/Severe
- ☐ F14.1x Cocaine Use, Mild
- ☐ F14.2x Cocaine Use, Moderate/Severe
- ☐ F18.1x Inhalant Use Disorder, Mild
- ☐ F18.2x Inhalant Use Disorder, Moderate/Severe
- ☐ F11.1x Opioid Use Disorder, Mild
- ☐ F11.2x Opioid Use Disorder, Moderate/Severe
- ☐ F13.1x Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild
- ☐ F13.2x Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate/Severe
- ☐ F17.200 Tobacco Use Disorder, Moderate/Severe
- ☐ F16.1x Other Hallucinogen/Phencyclidine Use Disorder, Mild
- ☐ F16.2x Other Hallucinogen/Phencyclidine Use Disorder, Moderate/Severe
- ☐ F19.1x Other or Unknown Substance Use Disorder, Mild
- ☐ F19.2x Other or Unknown Substance Use Disorder, Moderate/Severe

Trauma- and Stressor-Related Disorders
- ☐ F43.0 Acute Stress Disorder
- ☐ F43.2x Adjustment Disorder
- ☐ F43.1x Post-Traumatic Stress Disorder
- ☐ F43.8,F43.9 Other Specified/Unspecified Trauma and Stressor-Related Disorder

OTHER DIAGNOSES

Diagnoses—Check diagnoses here if it is provided by a health care provider or medical record (including hospital discharge forms, nursing home admission forms, etc.) Do not try to interpret people's complaints or medical histories. Contact health care providers instead.

☐ No current diagnoses

A. Brain/Central Nervous System
- ☐ Alzheimer's Disease
- ☐ Cerebral Vascular Accident (CVA, stroke)
- ☐ Seizure Disorder **with onset on or after age 22**
- ☐ Traumatic Brain Injury **on or after age 22**
- ☐ Other brain disorders—Specify:

  _____
- ☐ Other **Irreversible** Dementia—Specify:

  _____

B. Developmental Disability
- ☐ Autism
- ☐ Brain Injury **with onset before age 22**
- ☐ Cerebral Palsy
- ☐ Intellectual disability
- ☐ Prader-Willi Syndrome
- ☐ Seizure Disorder **with onset before age 22**
- ☐ Otherwise meets state or Federal definitions of DD

C. Endocrine/Metabolic
- ☐ Dehydration/fluid & electrolyte imbalances
- ☐ Diabetes Mellitus
- ☐ Hypothyroidism/Hyperthyroidism
- ☐ Liver Disease (hepatic failure, cirrhosis)
- ☐ Nutritional Imbalances (e.g., malnutrition, vitamin deficiencies, high cholesterol, hyperlipidemia)
- ☐ Other disorders of digestive system (mouth, esophagus, stomach, intestines, gall bladder, pancreas)—Specify:

  _____
- ☐ Other disorders of hormonal or metabolic system—Specify:

  _____

D. Heart/Circulation
- ☐ Anemia/Coagulation Defects/Other blood diseases
- ☐ Angina/Coronary Artery Disease/Myocardial Infarction (MI)
- ☐ Congestive Heart Failure (CHF)
- ☐ Disorders of blood vessels or lymphatic system
- ☐ Disorders of heart rate or rhythm
- ☐ Hypertension (HTN) (high blood pressure)
- ☐ Hypotension (low blood pressure)
- ☐ Other heart conditions (including valve disorders)—Specify:

  _____

E. Musculoskeletal/Neuromuscular
- ☐ Amputation
- ☐ Arthritis (e.g., osteoarthritis, rheumatoid arthritis)
- ☐ Contractures/Connective Tissue Disorders
- ☐ Hip fracture/replacement
- ☐ Multiple Sclerosis/ALS
- ☐ Muscular Dystrophy

E. Musculoskeletal/Neuromuscular (cont'd)
- ☐ Osteoporosis/Other bone disease
- ☐ Paralysis Other than Spinal Cord Injury
- ☐ Spina Bifida
- ☐ Spinal Cord Injury
- ☐ Other chronic pain or fatigue [e.g., Fibromyalgia, migraines, headaches, back pain (including discs), CFS]—Specify:

  _____
- ☐ Other fracture/joint disorders/Scoliosis/Kyphosis—Specify:

  _____
- ☐ Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders—Specify:

  _____

F. Respiratory
- ☐ Asthma/Chronic Obstructive Pulmonary Disease (COPD)/Emphysema/Chronic Bronchitis
- ☐ Pneumonia/Acute Bronchitis/Influenza
- ☐ Tracheostomy
- ☐ Ventilator Dependent
- ☐ Other respiratory condition—Specify:

  _____

G. Disorders Of Genitourinary System/Reproductive System
- ☐ Disorders of reproductive system
- ☐ Renal Failure, other kidney disease
- ☐ Urinary Tract Infection, current or recently recurrent
- ☐ Other disorders of GU system (bladder, urethra)—Specify:

  _____

H. Sensory
- ☐ Blind
- ☐ Deaf
- ☐ Visual impairment (e.g., cataracts, retinopathy, glaucoma, macular degeneration)
- ☐ Other sensory disorders—Specify:

  _____

I. Infections/Immune System
- ☐ AIDS (diagnosed)
- ☐ Allergies
- ☐ Auto-Immune Disease (other than rheumatism)
- ☐ Cancer in past five (5) years
- ☐ Diseases of skin
- ☐ HIV Positive
- ☐ Other infectious disease—Specify:

  _____

J. Other
- ☐ Terminal Illness (prognosis less than 12 months)
- ☐ Wound, Burn, Bedsore, Pressure Ulcer

SCREEN COMPLETION TIME

Date of Screen Completion (mm/dd/yyyy): _____

Time to Complete Screen	Hours	Minutes
Face-to-face contact with the applicant		
Collateral Contacts—either in person or indirect contact with any other people, including family, advocates, providers, etc.		
Paper Work—includes review of medical documents, etc.		
Travel Time		
Total Time to Complete Screen		