FUNCTIONAL ELIGIBILITY SCREEN

FOR MENTAL HEALTH AND MENTAL HEALTH & AODA (CO-OCCURRING) SERVICES

Basic Information

Basic Screen Information	
Screener's Name:	Screening Agency:
Referral Date (mm/dd/yyyy): / /	Screen Type (Check only one box): ❑ 01 Initial Screen ❑ 02 Annual Screen ❑ 03 Screen due to change in condition or situation (or by request)

Basic Applicant Information			
Title:	First Name:	Middle Name:	Last Name:

Gender:	Social Security Number (###-##-####):	Date of Birth (mm/dd/yyyy):
❑ Male ❑ Female	_ _	/ /

Applicant's Address		
Address:		
City:	State:	Zip:
Home Phone (###) ###-####:	Work Phone (###) ###-####:	Cell Phone (###) ###-####:

County / Tribe of Residence:	County / Tribe of Responsibility:

Directions: ____
____
____
____

TRANSFER INFORMATION

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

Referral date to service agency (mm/dd/yyyy):____/____/____ 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 - Please specify: ___________________________________
- ❑ Advocate
- ❑ Case Manager
- ❑ Hospital Staff
- ❑ Nursing Home Staff
- ❑ ICF-MR / State DD Center Staff
- ❑ Residential Providers (e.g., group home, AFH)
- ❑ Home Health, Personal Care, or Supportive Home Care Staff
- ❑ Probation / Parole Officer

❑ Other – Please specify: ___________________________________

Where Screen Interview was Conducted (Check only one box.)

- ❑ Person's Current Residence
- ❑ Temporary Residence (non-institutional)
- ❑ Nursing Home
- ❑ General Hospital
- ❑ Psychiatric Hospital or other IMD
- ❑ Agency Office, Resource Center

❑ Other – Please specify: ___________________________________

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	❑ Hmong
❑ Spanish	❑ Russian
❑ Vietnamese	❑ A Native American Language
❑ Other – Please specify: ______________________________	

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		
First Name:	Middle Name:	Last Name:
Address:		
Home Phone (###) ###-####:	Work Phone (###) ###-####:	Cell Phone (###) ###-####:
City:	State:	Zip:
Best time to contact and / or comments:		

Activated Power of Attorney for Health Care responsible for making decisions about medical care		
First Name:	Middle Name:	Last Name:
Address:		
Home Phone (###) ###-####:	Work Phone (###) ###-####:	Cell Phone (###) ###-####:
City:	State:	Zip:
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 – Please specify: ______________________________________		
First Name:	Middle Name:	Last Name:
Address:		
Home Phone (###) ###-####:	Work Phone (###) ###-####:	Cell Phone (###) ###-####:
City:	State:	Zip:
Best time to contact and / or comments:		

Living Situation

CURRENT RESIDENCE On this table, make **ONLY ONE** check-mark to indicate where the person lives now, and **ONLY ONE** check-mark to indicate where the person would like to live. For the latter, record the person's preference, not what is deemed realistic (e.g., safe, cost-effective), and not what anyone else prefers.

NOW LIVES	CURRENT RESIDENCE	PREFERS TO LIVE
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 systems	☐
Health Care Facility / Institution		
☐	Nursing Home (Includes rehabilitation facility if licensed as a nursing home)	☐
☐	ICF- MR / FDD / DD Center / State institution for 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) Please specify:______________________________	
	Unable to determine person's preference for living arrangement.	☐

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 & SSA benefits

Vocational / Educational Assistance

Needs Assistance To Find / Apply for Work:

- ❑ N/A
- ❑ 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.)

- ❑ N/A
- ❑ Independent
- ❑ Less than monthly
- ❑ 1 to 4 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.)

- ❑ N/A
- ❑ Independent
- ❑ Less than monthly
- ❑ 1 to 4 times a month
- ❑ More than one time per week

Community Living Skills Inventory

Check box if applicant needs assistance from another person, i.e., is unable to function successfully in these areas without assistance from others **within the past 6 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
- ❑ Less than monthly
- ❑ 1 to 4 times a month
- ❑ 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
- ❑ Less than monthly
- ❑ 1 to 4 times a month
- ❑ 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
- ❑ Less than monthly
- ❑ 1 to 4 times a month
- ❑ 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
- ❑ Less than monthly
- ❑ 1 to 4 times a month
- ❑ 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
- ❑ Less than monthly
- ❑ 1 to 4 times a month
- ❑ More than one time per week

Hygiene and Grooming: Needs assistance to maintain basic hygiene & grooming**.**

- ❑ Independent
- ❑ Less than monthly
- ❑ 1 to 4 times a month
- ❑ More than one time per week

Taking Medications: Needs assistance with taking medications, medication administration and assisting with self-administration, which includes set-up, 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)
- ❑ Independent
- ❑ Less than monthly
- ❑ 1 to 4 days a month
- ❑ 2 to 6 days per week
- ❑ 1 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
- ❑ 1 to 4 days a month
- ❑ 2 to 6 days per week
- ❑ 1 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 detox units						
❑ 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, etc.) *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 aggression 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 a suicidal ideation with a feasible plan within the past 2 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 person with a history of substance use who has been abstinent the last year.
- ❑ 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 experienced negative consequences in legal (including OWI), financial, family, relational, or health domains that are linked to substance use.

Answer the following five questions if one of the last two options were chosen for the Outcomes of Substance Use question:

Used Alcohol or Drugs Weekly. (Check only one box)

- ❑ In the last 30 days
- ❑ Not in the last 30 days but yes during the last year
- ❑ Not applicable

Spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick). (Check only one box)

- ❑ In the last 30 days
- ❑ Not in the last 30 days but yes during the last year
- ❑ Not applicable

Kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting into trouble with other people. (Check only one box)

- ❑ In the last 30 days
- ❑ Not in the last 30 days but yes during the last year
- ❑ Not applicable

Use of alcohol or drugs caused applicant to give up, reduce or have problems at important activities at work, school, home or social events. (Check only one box)

- ❑ In the last 30 days
- ❑ Not in the last 30 days but yes during the last year
- ❑ Not applicable

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. (Check only one box)

- ❑ In the last 30 days
- ❑ Not in the last 30 days but yes during the last year
- ❑ Not applicable

Substance Use Treatment (not detox)		
❑ Unknown	❑ No	❑ Yes Check all time periods that apply. ❑ Within past year ❑ 13 months to 3 years ago

Substance Use Peer Group Support (e.g., aftercare group, AA, NA)		
❑ 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 you have?		
❑ Unknown	❑ No	❑ Yes

Housing Instability		
❑ Unknown	❑ No	❑ Yes Check all boxes that apply to indicate type of housing instability within the past 12 months. ❑ Currently homeless (on the street or no 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 2 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 & 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

Adjustment Disorders

- ❑ 309.xx Adjustment Disorder (with anxiety, depression, disturbance of emotions, or conduct and NOS)

Anxiety Disorders

- ❑ 308.3 Acute Stress Disorder
- ❑ 300.00 Anxiety Disorder NOS
- ❑ 300.02 Generalized Anxiety Disorder
- ❑ 300.3 Obsessive-Compulsive Disorder
- ❑ 309.81 Post-Traumatic Stress Disorder
- ❑ 300.23 Social Phobia

Dissociative Disorder

- ❑ 300.15 Dissociative Disorder NOS
- ❑ 300.14 Dissociative Identity Disorder

Eating Disorders

- ❑ 307.1 Anorexia Nervosa
- ❑ 307.51 Bulimia Nervosa
- ❑ 307.50 Eating Disorders NOS

Impulse-Control Disorders

- ❑ 312.34 Intermittent Explosive Disorder
- ❑ 312.30 Impulse-Control Disorder NOS

Mood Disorders

- ❑ 296.xx Bipolar Disorder
- ❑ 301.13 Cyclothymic Disorder
- ❑ 311 Depressive Disorder NOS
- ❑ 300.4 Dysthymic Disorder
- ❑ 296.3x Major Depressive Disorder – Recurrent
- ❑ 296.2x Major Depressive Disorder – Single Episode
- ❑ 296.90 Mood Disorder NOS

Personality Disorders

- ❑ 301.7 Antisocial Personality Disorder
- ❑ 301.82 Avoidant Personality Disorder
- ❑ 301.83 Borderline Personality Disorder
- ❑ 301.6 Dependent Personality Disorder
- ❑ 301.50 Histrionic Personality Disorder
- ❑ 301.81 Narcissistic Personality Disorder
- ❑ 301.4 Obsessive-Compulsive Personality Disorder
- ❑ 301.0 Paranoid Personality Disorder
- ❑ 301.9 Personality Disorder NOS
- ❑ 301.20 Schizoid Personality Disorder
- ❑ 301.22 Schizotypal Personality Disorder

Schizophrenia & Other Psychotic Disorders

- ❑ 297.1 Delusional Disorder
- ❑ 298.9 Psychotic Disorder NOS
- ❑ 295.70 Schizoaffective Disorder
- ❑ 295.xx Schizophrenia
- ❑ 295.40 Schizophreniform Disorder
- ❑ 297.3 Shared Psychotic Disorder

Somatoform Disorders

- ❑ 300.7 Body Dysmorphic Disorder
- ❑ 300.11 Conversion Disorder
- ❑ 300.7 Hypochondriasis
- ❑ 307.xx Pain Disorder
- ❑ 300.xx Somatization Disorder

Substance-Related Disorders

- ❑ 305.00 Alcohol Abuse
- ❑ 303.90 Alcohol Dependence
- ❑ 305.70 Amphetamine Abuse
- ❑ 304.40 Amphetamine Dependence
- ❑ 305.20 Cannabis Abuse
- ❑ 304.30 Cannabis Dependence
- ❑ 305.60 Cocaine Abuse
- ❑ 304.20 Cocaine Dependence
- ❑ 305.30 Hallucinogen Abuse
- ❑ 304.50 Hallucinogen Dependence
- ❑ 305.90 Inhalant Abuse
- ❑ 304.60 Inhalant Dependence
- ❑ 305.10 Nicotine Dependence
- ❑ 305.50 Opioid Abuse
- ❑ 304.00 Opioid Dependence
- ❑ 305.90 Phencyclidine Abuse
- ❑ 304.90 Phencyclidine Dependence
- ❑ 304.80 Polysubstance Dependence
- ❑ 305.40 Sedative, Hypnotic, or Anxiolytic Abuse
- ❑ 304.10 Sedative, Hypnotic, or Anxiolytic Dependence
- ❑ 305.90 Other (or Unknown) Substance Abuse
  Please specify: ______________________________
- ❑ 304.90 Other (or Unknown) Substance Dependence
  Please specify: ______________________________
- ❑ Other Substance Related Disorder
  Please specify: ______________________________

Other Diagnoses

Diagnoses: Check diagnosis 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
  Please specify: ____________________
- ❑ Other Irreversible Dementia
  Please specify: ____________________

B. Developmental Disability

- ❑ Autism
- ❑ Brain Injury **with onset before age 22**
- ❑ Cerebral Palsy
- ❑ Mental Retardation
- ❑ 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)
  Please specify: ____________________
- ❑ Other disorders of hormonal or metabolic system
  Please 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)
  Please specify: ____________________

E. Musculoskeletal / Neuromuscular

- ❑ Amputation
- ❑ Arthritis (e.g., Osteoarthritis, Rheumatoid Arthritis)
- ❑ Contractures / Connective Tissue Disorders
- ❑ Hip fracture / replacement
- ❑ Multiple Sclerosis / ALS
- ❑ Muscular Dystrophy
- ❑ 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)
  Please specify: ____________________
- ❑ Other fracture / joint disorders / Scoliosis / Kyphosis
  Please specify: ____________________
- ❑ Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders
  Please specify: ____________________

F. Respiratory

- ❑ Asthma / Chronic Obstructive Pulmonary Disease (COPD) / Emphysema / Chronic Bronchitis
- ❑ Pneumonia / Acute Bronchitis / Influenza
- ❑ Tracheostomy
- ❑ Ventilator Dependent
- ❑ Other respiratory condition
  Please 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)
  Please specify: ____________________

H. Sensory

- ❑ Blind
- ❑ Deaf
- ❑ Visual impairment
  (e.g., cataracts, retinopathy, glaucoma, macular degeneration)
- ❑ Other sensory disorders
  Please specify: ____________________

I. Infections / Immune System

- ❑ AIDS (diagnosed)
- ❑ Allergies
- ❑ Auto-Immune Disease (other than rheumatism)
- ❑ Cancer in past 5 years
- ❑ Diseases of skin
- ❑ HIV Positive
- ❑ Other infectious disease
  Please specify:
  ____

J. Other

- ❑ Terminal Illness (prognosis ≤ 12 months)
- ❑ Wound, Burn, Bedsore, Pressure Ulcer

Screen Completion Time

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

Time to Complete Screen		
	Hours	**Minutes**
Face-to-Face contact with the person		
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		