

PreAdmission Screening Tool

Developmentally Disabled/Physically Disabled 12+

| Case Information | | | |
|------------------|--|-----------------|--|
| AHCCCS ID | | Medicare Part D | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Person/App ID: | | | |
| Type of PAS | <input type="checkbox"/> Initial <input type="checkbox"/> Reassessment <input type="checkbox"/> Posthumous | | |
| PSE Name | | | |
| PSE Phone | | | |

I. INTAKE INFORMATION

| Customer Information | | | |
|--------------------------------|---|----------|--|
| PAS Date | | PAS Time | |
| Customer Name: | | | |
| Age | | | |
| Birthdate | | | |
| Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| Location at time of Assessment | | | |
| Telephone Number | | | |

| | |
|------------|---|
| DD Status: | <input type="checkbox"/> Not DD <input type="checkbox"/> Potential DD <input type="checkbox"/> DD in NF <input type="checkbox"/> DD |
|------------|---|

| | | | | | | |
|----------------|----------|--|----------|--|----------|--|
| Prior Quarter: | Month 1: | | Month 2: | | Month 3: | |
|----------------|----------|--|----------|--|----------|--|

| Authorized Representative | |
|---------------------------|--|
| Name | |
| Telephone Number | |

| Physical Measurements | |
|--------------------------|----------------|
| Height | Feet Inches |
| Weight | lbs. |
| Birth Weight (DD 0-5) | lbs. |
| Gestational Age (DD 0-5) | |

| Additional Information | | | |
|------------------------|--|------------------------------|-----------------------------|
| 1. | Is customer currently hospitalized or in an intensive rehabilitation facility? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

I. Intake Information

PreAdmission Screening Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

| | | | |
|----|--|------------------------------|-----------------------------|
| 2. | If in an acute care facility, is discharge imminent (within 7 days)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| | Projected discharge date: | | |
| 3. | Ventilator Dependent? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. | Number of Emergency Room visits in last 6 months(EPD) | | |
| 5. | Number of Hospitalizations in last 6 months(last year for DD 0-5) | | |
| 6. | Number of Falls in last 90 days(EPD) | | |

| | | | | | |
|-------------------|--|-------|--|----------|--|
| Personal Contacts | | | | | |
| Contact #1 | | | | | |
| Name | | | | | |
| Relationship | | | | | |
| Address | | | | | |
| City | | State | | Zip Code | |
| Phone Number(s) | | | | | |
| Contact #2 | | | | | |
| Name | | | | | |
| Relationship | | | | | |
| Address | | | | | |
| City | | State | | Zip Code | |
| Phone Number(s) | | | | | |
| Contact #3 | | | | | |
| Name | | | | | |
| Relationship | | | | | |
| Address | | | | | |
| City | | State | | Zip Code | |
| Phone Number(s) | | | | | |
| Contact #4 | | | | | |
| Name | | | | | |
| Relationship | | | | | |
| Address | | | | | |
| City | | State | | Zip Code | |

I. Intake Information

PreAdmission Screening Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

| | |
|-----------------|--|
| Phone Number(s) | |
|-----------------|--|

| |
|--|
| |
|--|

INTERNAL USE ONLY

II. Functional Assessment

A. Motor/Independent Living Skills Domain

PreAdmission Screening
Developmentally Disabled/Physically Disabled
Ages 12+

Customer Name

Person ID

II. FUNCTIONAL ASSESSMENT

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (CONSIDER ONE YEAR)

Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

Give credit for the highest level of a skill which is **performed at least 75 percent of the time**. Only give credit for what the individual actually does, not for what the individual "can do" or "might be able to do." When a question groups many activities, rate the individual on his/her ability to complete the task as a whole.

HAND USE

If individual has one hand or use of one hand only, rate better hand.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Uses fingers independently of each other |
| <input type="checkbox"/> 1 | Uses thumbs and fingers of hand(s) in opposition |
| <input type="checkbox"/> 2 | Uses raking motion or grasps with hand(s) |
| <input type="checkbox"/> 3 | No functional use of hand(s) |

Comments:

AMBULATION

Use of special assistive devices (e.g., canes, walkers, braces) should not affect rating.

- | | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Walks well alone for normal distances and on all terrains |
| <input type="checkbox"/> 1 | Walks well alone for a short distance (10 - 20 feet); balances well; distance limitation may be due to terrain. |
| <input type="checkbox"/> 2 | Walks unsteadily alone for a short distance (10 - 20 feet) |
| <input type="checkbox"/> 3 | Walks only with physical assistance from others |
| <input type="checkbox"/> 4 | Does not walk |

Comments:

WHEELCHAIR MOBILITY

Wheelchair may be motorized or manual.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Wheelchair is not used or moves wheelchair independently |
| <input type="checkbox"/> 1 | Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering) |

II. Functional Assessment

A. Motor/Independent Living Skills Domain

PreAdmission Screening

Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

☐ 2 Individual needs some, but not total assistance, in moving wheelchair

☐ 3 Needs total assistance for moving wheelchair

Comments:

TRANSFER

Degree of human assistance necessary on a consistent basis for transfer, such as assistance in getting into wheelchair, getting on and off toilet, into and out of bed, in and out of shower/tub. Rate these items ONLY with regard to the need for human intervention, NOT with regard to the need for assistive devices. Ability to transfer in and out of a vehicle is not rated.

☐ 0 No problem in this area; does transfer self independently but may require use of assistive devices

☐ 1 Needs hands-on physical guidance, but does not have to be physically lifted, OR needs supervision with more than half of transferring activities

☐ 2 Needs to be physically lifted or moved, but can participate physically

☐ 3 Must be totally transferred by one or more persons OR is bedfast

Comments:

EATING/DRINKING

Rate tasks involved in eating food and/or drinking beverages served.

☐ 0 Completes the task independently

☐ 1 Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., plate guard, built-up spoon, cutting of food)

☐ 2 Requires hands-on assistance to initiate/complete the task (e.g., place utensils in hand, hand-over-hand scooping, or other assistance)

☐ 3 Does not perform this task even when assisted; is fed

☐ 4 Individual is tube fed

Comments:

II. Functional Assessment

A. Motor/Independent Living Skills Domain

PreAdmission Screening

Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

DRESSING

Putting on and removing regular articles of clothing, (e.g., skirt, blouse, shirt, pants, dress, shorts, socks and shoes, underwear). This does NOT include braces, nor does it reflect the individual's ability to match colors or choose clothing appropriate for the weather. Do NOT include care of clothing.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying-out of clothes) |
| <input type="checkbox"/> 2 | Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners) |
| <input type="checkbox"/> 3 | Is not able to actively perform any part of this task but can physically participate |
| <input type="checkbox"/> 4 | Requires total hands-on assistance and does not physically participate |

Comments:

PERSONAL HYGIENE

Those tasks involved in basic grooming, including hair care, brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications |
| <input type="checkbox"/> 2 | Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands on assistance to comb hair). |
| <input type="checkbox"/> 3 | This task must be done for the individual but individual can physically participate |
| <input type="checkbox"/> 4 | Requires total hands-on assistance and does not physically participate |

Comments:

BATHING OR SHOWERING

Washing body (e.g., bath, shower, sponge bath, or bed bath) includes shampooing hair

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Requires verbal prompts for washing and drying or help with drawing water, checking temperature |
| <input type="checkbox"/> 2 | Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g. |

II. Functional Assessment

A. Motor/Independent Living Skills Domain

PreAdmission Screening

Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

shampooing.)

- ☐ 3 Requires hands-on assistance during entire bathing process but can physically participate
- ☐ 4 Requires total hands on assistance and does not physically participate

Comments:

FOOD PREPARATION

Preparation of simple meals, such as sandwiches, cold cereal, frozen dinners, eggs. Rate the item independent of the heating sources used (e.g., microwave, regular oven, stove top – may use only the microwave and still be independent).

- ☐ 0 Completes the task independently
- ☐ 1 Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications
- ☐ 2 Requires hands-on assistance to initiate/complete the task
- ☐ 3 Does not perform this task, even when assisted; the task must be done for the person

Comments:

COMMUNITY MOBILITY

Movement around the neighborhood or community, including accessing buildings, stores, and restaurants, and using any mode of transportation, such as walking, wheelchair, cars, buses, taxis, bicycles.

- ☐ 0 Moves about the neighborhood or community independently without assistance
- ☐ 1 Moves about the neighborhood or community independently for a complex trip (several stops, unfamiliar places, bus transfers) with instructions and/or directions
- ☐ 2 Moves about the neighborhood or community independently for a simple direct trip and/or familiar locations with instructions and/or directions
- ☐ 3 Moves about the neighborhood or community with some physical assistance and/or occasional accompaniment
- ☐ 4 Moves about the neighborhood or community only with accompaniment

Comments:

II. Functional Assessment

A. Motor/Independent Living Skills Domain

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 12+

Customer Name

Person ID

TOILETING

Involves initiating and caring for those bodily functions involving bowel and bladder control. NOTE: Do NOT rate ability to wash hands after toileting or the ability to transfer on and off the toilet.

| | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Completes the task independently |
| <input type="checkbox"/> 1 | Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications |
| <input type="checkbox"/> 2 | Can indicate the need for toileting, but requires hands-on assist to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet) |
| <input type="checkbox"/> 3 | Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assist to complete/perform the task |
| <input type="checkbox"/> 4 | Does not perform nor indicate the need for toileting and requires total caregiver intervention |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

If bladder accidents occur, how frequently?

Times per ☐ Day ☐ Month ☐ Year

II. Functional Assessment

B. Communication/Cognitive Domain

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 12+

Customer Name

Person ID

B. COMMUNICATION/COGNITIVE DOMAIN

EXPRESSIVE VERBAL COMMUNICATION

Ability to communicate thoughts verbally with words or sounds.

| | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Carries on a complex or detailed conversation |
| <input type="checkbox"/> 1 | Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing) |
| <input type="checkbox"/> 2 | Uses simple two-word phrases (e.g., "I go," "give me") |
| <input type="checkbox"/> 3 | Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities |
| <input type="checkbox"/> 4 | Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts |
| <input type="checkbox"/> 5 | Makes no sounds which are for communication; may babble, cry or laugh |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

CLARITY OF COMMUNICATION

Ability to speak in a recognizable language or use a formal symbolic substitute, such as American Sign Language or alternate communication system. If has more than one form of communication, score on what is best understood.

| | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand this individual |
| <input type="checkbox"/> 1 | Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand |
| <input type="checkbox"/> 2 | Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing) |
| <input type="checkbox"/> 3 | Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system |
| <input type="checkbox"/> 4 | Does not communicate using a recognizable language or formal symbolic substitutions |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

II. Functional Assessment

B. Communication/Cognitive Domain

PreAdmission Screening

Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

ASSOCIATING TIME WITH EVENTS AND ACTIONS

Indicate person's sense of time. Note: does NOT have to tell time.

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Associates events with specific time (e.g., the concert starts at 7:45) |
| <input type="checkbox"/> 1 | Associates regular events with specific hour (e.g., dinner is at six, work starts at eight, bedtime is at ten) |
| <input type="checkbox"/> 2 | Associates regular events with morning, noon, or night (e.g., daily or weekly events, such as we go to school in the morning or I go to bed at night); does not understand time but knows the sequence of daily events |
| <input type="checkbox"/> 3 | Does not associate events and actions with time |

Comments:

REMEMBERING INSTRUCTIONS AND DEMONSTRATIONS

Can recall examples of instructions or demonstrations on how to complete a specific task as demonstrated and/or verbally directed. Comments **MUST include examples of tasks assessed.**

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Displays memory of instructions or demonstrations without prompting if they are given once |
| <input type="checkbox"/> 1 | Displays memory of instructions or demonstrations if they are given once and if prompted to recall |
| <input type="checkbox"/> 2 | Displays memory of instructions or demonstrations if they are repeated three or more times and if prompted to recall |
| <input type="checkbox"/> 3 | Displays no or extremely limited (rare or very incomplete) memory of instructions or demonstrations |

Comments:

II. Functional Assessment C. Behavioral Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 12+

Customer Name

Person ID

C BEHAVIORAL DOMAIN

ALL BEHAVIORS IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN COMMENTS AND THE INTERVENTION SPECIFIED.

AGGRESSION

Physical attacks on others, including throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. Do NOT include self-injurious behaviors, threatening or property destruction.

| | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Problem does not occur or occurs at a level not requiring intervention |
| <input type="checkbox"/> 1 | Minor problem; occasional aggression which requires some additional supervision in a few situations and/or verbal redirection |
| <input type="checkbox"/> 2 | Moderate problem; frequent aggression that requires close supervision and/or physical redirection |
| <input type="checkbox"/> 3 | Serious problem; constant aggression that requires close supervision and/or constant verbal or physical interruption. |
| <input type="checkbox"/> 4 | Extremely Urgent problem; has had episode(s) causing injury in the last year, requires close supervision and physical interruption |

Comments:

VERBAL OR PHYSICAL THREATENING

Threatens to do harm to self, others or objects. Do NOT include actual acts of physical aggression or self-injury.

| | |
|----------------------------|---|
| <input type="checkbox"/> 0 | Problem does not occur or occurs at a level not requiring intervention |
| <input type="checkbox"/> 1 | Minor problem; makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection |
| <input type="checkbox"/> 2 | Moderate problem; makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and physical redirection |
| <input type="checkbox"/> 3 | Serious problem; makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption |
| <input type="checkbox"/> 4 | Extremely Urgent problem; has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption. |

Comments:

II. Functional Assessment C. Behavioral Domain

PreAdmission Screening Developmentally Disabled/Physically Disabled Ages 12+

Customer Name

Person ID

SELF-INJURIOUS BEHAVIOR

Biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, head slapping or banging.

| | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Problem does not occur or occurs at a level not requiring intervention |
| <input type="checkbox"/> 1 | Minor problem; occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection |
| <input type="checkbox"/> 2 | Moderate problem; frequent incidents that require close supervision and/or physical redirection |
| <input type="checkbox"/> 3 | Serious problem; constant incidents; requires close supervision and/or verbal or physical interruption |
| <input type="checkbox"/> 4 | Extremely Urgent problem; has had episode(s) causing serious injury requiring immediate medical attention in the <u>last year</u> , requires close supervision and physical interruption |

Comments:

RESISTIVENESS/REBELLIOUSNESS

Inappropriately stubborn and or uncooperative, including passive or active obstinate behaviors. Do NOT include difficulties with auditory processing or reasonable expressions of self-advocacy. Do NOT include verbal threatening or acts of physical aggression to self or others.

| | |
|----------------------------|--|
| <input type="checkbox"/> 0 | Problem does not occur or occurs at a level not requiring intervention |
| <input type="checkbox"/> 1 | Minor problem; occurs occasionally and requires occasional attention, prompting and/or verbal redirection for cooperation |
| <input type="checkbox"/> 2 | Moderate problem; occurs frequently and requires frequent attention, prompting and/or physical redirection for cooperation |
| <input type="checkbox"/> 3 | Serious problem; occurs constantly and requires constant attention, prompting and/or physical redirection for cooperation |

Comments:

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disable/Physically Disabled

Ages 12+

Customer Name

Person ID

III. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS

A = Acute, C = Chronic, H = History (Check appropriate answers)

| | <u>A, C, H</u> | <u>Comments</u> | <u>Major Dx</u> |
|--|--|-----------------|-----------------|
| Neurological/Congenital/Developmental Conditions | | | |
| 1. Cerebral Palsy | | | |
| a. Diplegia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. Hemiplegia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. Quadriplegia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. Paraplegia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. Unspecified Cerebral Palsy | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 2. Epilepsy/Seizure Disorder | | | |
| NOTE: Indicate DATE of LAST Seizure and FREQUENCY of EACH TYPE of Seizure in Comments. | | | |
| a. Generalized non-convulsive (absence, petit mal, minor, akinetic, atonic.) | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. Generalized convulsive (clonic, myoclonic, tonic, tonic-clonic, grand mal, major) | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. Unspecified (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsy partialis, continual | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 3. Mental Intellectual/Cognitive Disability | | | |
| a. Mild Intellectual/Cognitive Disability | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. Moderate Intellectual/Cognitive Disability | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. Severe Intellectual/Cognitive Disability | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. Profound | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disable/Physically Disabled

Ages 12+

Customer Name

Person ID

| | | | | |
|--|---|--|--|--|
| | Intellectual/Cognitive Disability | | | |
| e. | Unspecified Intellectual/Cognitive Disability | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| f. | Borderline Intelligence | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 4. Autism | | | | |
| a. | Autism | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Pervasive Developmental Disorder | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Autistic-Like Behaviors | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 5. Attention Deficit Disorder (ADD) | | | | |
| a. | ADD with Hyperactivity | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | ADD without Hyperactivity | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 6. Other Neurological / Congenital / Developmental Conditions | | | | |
| a. | Prematurity | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Fetal Alcohol Syndrome | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Developmental Delays | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Hydrocephaly | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Macrocephaly | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| f. | Microcephaly | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| g. | Meningitis | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| h. | Encephalopathy | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| i. | Spina Bifida | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| j. | Genetic Anomalies | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| k. | Down's Syndrome | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| l. | Congenital Anomalies | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| m. | Near Drowning | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| n. | Head Trauma | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| o. | Dementia (Organic Brain Syndrome) | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

| Other Medical Conditions | | | | |
|---------------------------|--|--|--|--|
| 7. Hematologic | | | | |
| a. | Anemia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | HIV Positive | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | AIDS | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Leukemia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Hepatitis | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 8. Cardiovascular | | | | |
| a. | CHF | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Hypertension | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Congenital Anomalies of Heart | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Cardiac Murmurs | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Rheumatic Heart Disease | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 9. Musculoskeletal | | | | |
| a. | Arthritis | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Fracture | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Contracture | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis) | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Paralysis | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 10. Respiratory | | | | |
| a. | Asthma | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Bronchitis | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Pneumonia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Respiratory Distress Syndrome | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Bronchopulmonary Dysplasia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| f. | Cystic Fibrosis | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| g. | Reactive Airway Disease | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 12+

Customer Name

Person ID

| | | | | |
|-----------------------------|---|--|--|--|
| h. | Tracheomalacia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| i. | Congenital Pulmonary Problems | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 11. Genitourinary | | | | |
| a. | Urinary Tract Infection | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 12. Gastrointestinal | | | | |
| a. | Constipation | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Ulcers | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Hernia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Esophagitis | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Gastroesophageal Reflux | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 13. EENT | | | | |
| a. | Blindness | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Cataract | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Hearing Deficit | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Ear Infection | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus) | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| f. | Glaucoma | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 14. Metabolic | | | | |
| a. | Hypothyroidism | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Hyperthyroidism | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Diabetes Mellitus | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| d. | Pituitary Problem | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 15. Skin Conditions | | | | |
| a. | Decubitus | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Acne | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| 16. Psychiatric | | | | |
| a. | Major Depression | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| b. | Bipolar Disorder | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| c. | Schizophrenia | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |

III. Medical Assessment

A. Medical Conditions

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 12+

Customer Name

Person ID

| | | | | |
|----|----------------------|--|--|--|
| d. | Behavioral Disorders | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| e. | Conduct Disorder | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| f. | Alcohol Abuse | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |
| g. | Drug Abuse | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | | |

| 17. Other Diagnoses | | | | | | | | | Diagnosis |
|---------------------|----|--|--|--|--|--|--|--|-----------|
| ICD-10 | a. | | | | | | | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | |
| ICD-10 | b. | | | | | | | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | |
| ICD-10 | c. | | | | | | | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | |
| ICD-10 | d. | | | | | | | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | |
| ICD-10 | e. | | | | | | | <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> H | |

| | Category | Condition | Diagnosis |
|-----------------|----------|-----------|-----------|
| MAJOR DIAGNOSES | | | |
| | | | |
| | | | |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

III. Medical Assessment
B. Medications/Treatments

PreAdmission Screening
Developmentally Disable/Physically Disabled
Ages 12+

Customer Name

Person ID

B. MEDICATIONS/TREATMENTS

(Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments). Include dosage, frequency, duration, route, form for each medication.

| MEDICATIONS / TREATMENTS / COMMENTS | | RX | OTC |
|-------------------------------------|--|--------------------------|--------------------------|
| 1. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | | <input type="checkbox"/> | <input type="checkbox"/> |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

C. SERVICES AND TREATMENTS

(Mark appropriate answers) Provide explanation when (N) is circled

| | Frequency of Service | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. Injections/IV | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
| a. Intravenous Infusion Therapy | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Intramuscular/Subcutaneous Injections | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 2. Medications/Monitoring | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
|---------------------------|---------------------------------------|----------------------------|---------------------------------------|---------------------------------------|----------------------------|----------------------------|
| a. Drug Regulation | <input checked="" type="checkbox"/> R | <input type="checkbox"/> N | <input checked="" type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Drug Administration | <input checked="" type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input checked="" type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 3. Dressings | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
|----------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Decubitus Care | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Wound Care | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| c. Non-Bladder/Bowel Ostomy Care | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 4. Feedings | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Parenteral Feedings/TPN | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Tube Feedings | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 5. Bladder/Bowel | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
|------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Catheter Care | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Ostomy Care | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

III. Medical Assessment

B. Medications/Treatments

PreAdmission Screening

Developmentally Disabled/Physically Disabled

Ages 12+

Customer Name

Person ID

| | | | | | | |
|---------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| c. Bowel Dilatation | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
|---------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 6. Respiratory | Frequency of Service | | | | | |
|----------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
| a. Suctioning | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Oxygen | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| c. SVN | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| d. Ventilator | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| e. Trach Care | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| f. Postural Drainage | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| g. Apnea Monitor | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 7. Therapies | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
|------------------------------------|---------------------------------------|----------------------------|----------------------------|----------------------------|---------------------------------------|----------------------------|
| a. Physical Therapy | <input checked="" type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input checked="" type="checkbox"/> W | <input type="checkbox"/> M |
| b. Occupational Therapy | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| c. Speech Therapy | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| d. Respiratory Therapy | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| e. Alcohol/Drug Treatment | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| f. Vocational Rehabilitation | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| g. Individual/Group Therapy | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| h. Behavioral Modification Program | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

III. Medical Assessment

B. Medications/Treatments

PreAdmission Screening

Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 8. Rehabilitative Nursing | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
|----------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Teaching/Training Program | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Bowel/Bladder Retraining | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| c. Turning & Positioning | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| d. Range of Motion | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| e. Other Rehab Nursing (specify) | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

| 9. Other | Receives | Needs | Cont. | Daily | Wkly. | Monthly |
|---------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Peritoneal Dialysis | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| b. Hemodialysis | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| c. Chemotherapy/Radiation | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| d. Restraints | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| e. Fluid Intake/Output | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |
| f. Other (specify) | <input type="checkbox"/> R | <input type="checkbox"/> N | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

III. Medical Assessment
D. Medical Stability

PreAdmission Screening
Developmentally Disabled/Physically Disabled
Ages 12+

Customer Name

Person ID

D. MEDICAL STABILITY

| | |
|--|--|
| 1. Record the number of acute hospitalizations that occurred over the past year | |
| 2. Currently requires direct care staff or caregiver trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Currently requires special diet planned by dietitian, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed) | <input type="checkbox"/> YES <input type="checkbox"/> NO |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

III. Medical Assessment
E. Sensory Functions

PreAdmission Screening
Developmentally Disable/Physically Disabled
Ages 12+

Customer Name

Person ID

E. SENSORY FUNCTIONS

(mark appropriate answers)

| | Unable to Assess/ <u>No Impairment</u> | Minimum <u>Impairment</u> | Moderate <u>Impairment</u> | Severe <u>Impairment</u> |
|---|---|------------------------------|-------------------------------|-----------------------------|
| 1. Hearing Ability to perceive sounds | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 2. Vision Ability to perceive objects visually | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

| | |
|-----------|--|
| Comments: | |
|-----------|--|

III. Medical Assessment F. Summary Evaluation

PreAdmission Screening Developmentally Disable/Physically Disabled Ages 12+

Customer Name

Person ID

F. SUMMARY EVALUATION

| |
|--|
| PCP: and other informants names for Personal Contacts entries |
| |

| | | | |
|-------------------------------|--|------|--|
| ELIGIBILITY REVIEW REQUESTED? | <input type="checkbox"/> Yes <input type="checkbox"/> No | DATE | |
|-------------------------------|--|------|--|

| | | | |
|---------------------------|-------|-----------------------|--|
| Signature | Title | Date | |
| | | | |
| Signature and Title | Title | Date | |
| | | | |
| Completion Time (minutes) | | Travel Time (minutes) | |