Colorado Intake Screen Tool

Items in Green indicate a skip pattern.
Items in Purple are script for staff.
Items in Red indicate additional directions for assessors.
Items in italicized blue indicate notes related to automation.

I. Reason for Contact

Hello. My name is [staff person name] from the [agency name]. The [agency name] provides services through a variety of programs that help individuals perform their day to day tasks. How may I help you today?

1. Record opening narrative:

   _____
   _____
   _____
   _____
   _____
   _____

2. Immediate referral to 911 [Code based on response]
   - ❍ No
   - ❍ Yes [Contact 911 and collect information for follow-up] [Provide information and skip to Section VIII. Outcomes and Referrals]
3. Have a potential LTSS need? [ask follow-up questions if necessary]
   - ❍ No [Provide information and referral and skip to Section VIII. Outcomes and Referrals to document the type of information and/or referral provided and other outcomes.]
   - ❍ Yes, individual should continue with the Screen
   - ❍ Yes, information provided justifies moving forward with an Assessment [Skip to Section V. Financial Information]

II. Caller and/or Individual Seeking Supports' Information

1. Name of Individual Seeking Supports:_____
2. Is there a record for the individual in the automated system? *[Note: The actual structure of this will need to be adapted based upon the capabilities of the automation platform]*
   - ❍ No [Skip to 3]
   - ❍ Yes [Review previous contacts and verify that the information in 5A-S is correct]
   - ❍ Unknown
1. Currently enrolled in a HCBS program or had HCBS assessment?
   - ❍ No [Skip to 3] ❍ Yes
2. Given the individual history, which action is appropriate?
   - ❍ Conduct Screen
   - ❍ Conduct Assessment [Skip to Section VII. Assessment Pathway]
   - ❍ Neither [Skip to Section VIII. Outcomes and Referrals]
3.

Commented [SL1]: Change to more flexible bullet points. Change description so that they are coordinating services. Include instructions for agencies to customize it to each agency. Help to coordinate services and provide referrals.
Greeting
Allow caller to identify her/himself
Overview of agency
How may I help you/reason for contact

Commented [SL2]: Language about checking if they are in the automated system.

Commented [SL3]: Update.

4.
5.
6. Who initiated the call?
   ❍ Individual seeking supports [Skip to 5] ❍Representative ❍Referral through PEAK
7. Representative information:
   A. Name:_____
   B. Representative agency (if applicable):_____

C. What is the relationship to the individual seeking supports?
❍ Spouse ❍ Child or Child-in-law ❍ Parent/Guardian
❍ Parent/Non-guardian ❍ Guardian, other:_____
❍ Partner/Significant Other ❍ Other relative ❍ Friend
❍ Neighbor ❍ Other informal helper ❍ Service/Provider Agency

D. Mobile telephone number:_____
E. Home telephone number:_____
F. Work phone number:_____
G. Email:_____
H. Preferred method of contact:
❍ Email ❍Mobile phone ❍Work phone ❍Home phone

8. Individual seeking supports' information:
A. Date of Birth: ___/___/_____
B. Age:____ [auto-calculate in automated version]
C. Gender:_____
D. Mobile telephone number:_____
E. Home telephone number:_____
F. Work phone number:_____
G. Email: _____
H. Preferred method of contact:
❍ Email ❍Mobile phone ❍Work phone ❍Home phone
I. Social Security #:_____-___-_____
J. Current Living Situation:
❍ Alone ❍ With Spouse/Others ❍ With Non-Spouse Relatives
❍ With Parents ❍ With Non-Relatives ❍ Alternative Care Facility
❍ Adult Foster Care ❍ Nursing Facility ❍ Hospital Discharge, Date:_____
❍ Pending Nursing Facility Discharge/Admission ❍ DD residential Program
❍ ICF/IID ❍ Other, specify:_____
[If the individual seeking supports' current residence is a Nursing Facility or Hospital, document the need for an expedited assessment in section VIII. Outcomes and Referrals]
K. Address:_____
L. Facility name (if applicable):_____
M. County of residence:_____
N. Does the individual have a physician who acts as a primary care provider?
❍ Yes ❍ No [Skip to Section III]
O. Physician/clinic name:_____
P. Physician address:_____
Q. Physician telephone number:_____

III. Determining if Screen is Appropriate

3. Is the individual willing to answer additional questions and proceed with the remainder of the Screen?

- ❍ No [Provide information and referral and skip to Section VIII. Outcomes and Referrals to document the type of information and/or referral provided and other outcomes.]
- ❍ Yes, continue with Screen
- ❍ Individual uncomfortable/unable to complete Screen via the telephone, but assessment appropriate. [Skip to Section V. Financial Information]

4. If Caller is not the individual seeking services, does caller have individual's permission to talk with agency? [If the caller is the individual seeking services, skip to 6.]
   ❍ No ❍ Yes ❍ Caller is individual seeking services
   [Ask if individual seeking services is available to talk at this time. If the individual and/or an authorized representative is not available and has not been given permission, consult a supervisor about how to proceed.]
5. Continue with screen?
   ❍ No [Skip to Section VIII. Outcomes and Referrals] ❍ Yes
6. Does the caller have any barriers to completing the Screen?
   ❍ No [Skip to Section IV. Eligibility Screen]
   ❍ Yes, describe:_____
   _____
   [Determine actions that need to be addressed to accommodate the challenges. Consult with a supervisor if necessary.]
7. Continue with screen?
   ❍ No [Skip to Section VIII. Outcomes and Referrals] ❍ Yes

Commented [SL4]: Move this earlier

Commented [SL5]: Move to section 2

IV. Eligibility Screen

1. Does the individual have any difficulty with any of the following ADLs:
   ☐ Bathing ☐ Toileting
   ☐ Dressing ☐ Transferring
   ☐ Eating ☐ Mobility

Commented [SL6]: Add comment box

2. Does the individual display/have any memory or cognitive impairments?
   ❍ Yes ❍ No ❍ Uncertain

If yes or uncertain, describe: _____
_____

3. Does the individual display/have any behavior issues?
   ❍ Yes ❍ No ❍ Uncertain

If yes or uncertain, describe:_____
_____

4. Is an assessment justified [Triggered 2 or more ADLs or yes on questions 2 or 3 or uncertain on questions 2 or 3 suggests there may be an issue]?
   - ❍ Yes [Skip to V. Financial Information]
   - ❍ No [Inform individual that the screen indicates that he/she is not likely eligible for services, however he/she has the right to an assessment]
5. Continue with screen?
   - ❍ No [Skip to Section VIII. Outcomes and Referrals] ❍ Yes

V. Financial Information

Financial information topics to be addressed with individual by Intake Staff:

- Because these services are funded under Medicaid, to be eligible for services, income and, in some cases, assets must be below certain levels
- The exact levels vary based upon a number of factors, such as marital status and whether you work
- There is a separate financial eligibility process
- Medicaid application must be started prior to receiving an assessment

1. Does the individual have Medicaid? *[Note: Check client record to see if they are enrolled in or have applied for Medicaid]*
   - ❍ No ❍Yes [Skip to Section VI. Risk Trigger Screen]
2. Does the individual receive Supplemental Security Income (SSI)?
   - ❍ No
   - ❍ Yes [Assist the individual in completing the Request for Long Term Care form for individuals receiving SSI and Skip to VI. Risk Trigger Screen]
3. Does the individual wish to continue?
   - ❍ No [Provide information and referral and skip to Section VIII. Outcomes and Referrals to document the type of information and/or referral provided and other outcomes.]
   - ❍ Yes
4. Has the individual begun the Medicaid application process?
   - ❍ No [Assist individual in beginning the application process or provide referral to local agency application assistance site, DHS, or PEAK. Document this referral in Section VIII. Outcomes and Referrals. Continue with the process.]
   - ❍ Yes, date application submitted:_____

VI. Risk Trigger Screen

Commented [SL7]: Add skip ability if not at high risk

1. Number of hospitalizations in the past six months:_____
2. Number of emergency room visits in the past six months:_____
3. Number of calls to 911 in the past six months:_____
4. Based on the individual's presenting needs, how likely is he/she to be placed in a nursing facility in the next three months?

❍ Very likely ❍Somewhat likely ❍Not likely

For the following questions, check the box if the scenario applies to the individual. Provide an additional explanation and the potential need for an expedited determination for each item that is checked in 14.

Question	Check if Applicable
5. Child and/or Adult Protective Services have been involved in the individual's life.	☐
6. The individual lives alone.	☐
7. The individual has had inpatient, psychiatric, or neurobehavioral hospital admission(s).	☐
8. The individual has resided in a nursing facility in the past year.	☐
9. The individual has recently experienced a loss of caregiver support.	☐
10. The individual is at risk of becoming homeless.	☐
11. The individual has had interaction with the police and/or legal system in the past 6 months.	☐
12. Based on staff judgment, the individual is at risk of institutional placement and/or health or safety is at risk.	☐
13. Based on the above responses, the individual should receive an expedited eligibility determination.	☐

Commented [SL8]: Add question about substantial change in heath (e.g., new chronic illness)
Add question about terminal illness
Add question about whether the individual is on hospice

14. Describe factors above or other factors that present a risk to institutionalization or threat to health and safety:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

VII. Assessment Pathway

1. Does the individual have a potential intellectual and/or developmental disability?
   ❍ No [Skip to 7 and select Non-IDD Assessment] ❍Yes
2. Is residential services through the IDD waiver the only option the individual is interested in? [explain residential options]
   ❍ No [Skip to 4]

Commented [SL9]: Add definition of IDD

❍ Yes

3. Does the individual have a DD Determination form on file?
   - ❍ No/unknown [Provide a referral so that the appropriate entity can complete the form. Document the referral and need for follow-up in Section VIII. Outcomes and Referrals.]
   - ❍ Yes [Refer case to appropriate staff/entity to assign individual to DD Waitlist and inform individual of next steps.]
     [Skip to VIII. Outcomes and Referrals]
4. Did the individual have a brain injury?
   - ❍ No [Skip to 6] ❍Yes

   [If Yes, explain the services and supports offered under the Brain Injury (BI) Waiver]
5. Does the individual wish to pursue the BI Waiver?
   - ❍ No ❍Yes [Skip to 7 and select Non-IDD Assessment]
6. Would the individual like to be assessed for assisted living?
   - ❍ No [Select IDD Assessment in 7]
   - ❍ Yes [Select Non-IDD Assessment in 7]
7. Based on the above responses, which Assessment will the individual receive?
   - ❍ Non-IDD Assessment [Skip to 9]
   - ❍ IDD Assessment
8. Does the individual have a DD Determination form on file?
   - ❍ No/unknown [Provide a referral so that the appropriate entity can complete the form. Document the referral and need for follow-up in Section VIII. Outcomes and Referrals. In the follow-up, if the individual is not able to get the determination in a timely manner, he/she should receive the non-IDD Assessment.][Skip to Section VIII. Outcomes and Referrals]
   - ❍ Yes
9. Schedule Assessment:
   A. Will staff conducting the Intake Screen be scheduling the assessment?
      - ❍ Yes
      - ❍ No [Refer scheduling the assessment (items B-E) to appropriate staff and skip to F]
   B. Assessment date and time:_____
   C. Assessment location:
      - ❍ In person at individual's home
      - ❍ In person at agency
      - ❍ In person at other location
      - ❍ Via telephone [Skip to E]
   D. Assessment address:_____
   E. Preferred individual phone number: _____
   F. Does the individual want <u>or</u> need someone to help make decisions about health care, money, or other issues?
      - ❍ No [Skip to J] ❍ Yes
   G. Does the individual have someone who assists with decision making?
      - ❍ No ❍ Yes [Skip to I]
   H. Would the individual want additional assistance making decisions?

❍ No
❍ Yes [Consult with supervisor to determine what additional assistance should be provided at assessment.] [Skip to J]

I. Information about decision maker:
1. Name:_____
2. What is the relationship to the person seeking supports?
❍ Spouse ❍ Child or Child-in-law ❍ Parent/Guardian
❍ Parent/Non-guardian ❍ Guardian, other:_____
❍ Partner/Significant Other ❍ Other relative ❍ Friend
❍ Neighbor ❍ Other informal helper ❍ Service/Provider Agency
3. Decision maker telephone number:_____
4. Does this person have the legal authority to make decisions or sign papers for the individual?
❍ No ❍ Yes ❍ Unsure
[If Yes or Unsure, have individual and/or decision maker bring documentation of this authority to the assessment]
5. Will decision maker be present at assessment?
❍ No ❍ Yes ❍ Unsure
6. Comments:_____
_____

J. Others who should be present at assessment:
1. Name:_____
2. What is the relationship to the person seeking supports?
❍ Spouse ❍ Child or Child-in-law ❍ Parent/Guardian
❍ Parent/Non-guardian ❍ Guardian, other:_____
❍ Partner/Significant Other ❍ Other relative ❍ Friend
❍ Neighbor ❍ Other informal helper ❍ Service/Provider Agency
3. Telephone number:_____
4. Comments:_____
_____

K. Special accommodations and assistance needed, including how best to maximize the individual's participation:_____
_____
_____

L. Additional information (e.g., specific directions/apartment codes, beware of dog, etc.):_____
_____

VIII. Outcomes and Referrals

1. Status of Screen:
   - ❍ Complete
   - ❍ Incomplete- Actions to complete:_____
     _____
2. Referral(s) provided (Check all that apply):
   - ☐ None
   - ☐ Crisis services
   - ☐ Child or Adult Protection Services
   - ☐ Housing assistance
   - ☐ Assistance with completing Medicaid application
   - ☐ Mental Health Center/BHO
   - ☐ RCCO
   - ☐ DD Determination
   - ☐ Center for Independent Living
   - ☐ Area Agency on Aging
   - ☐ Staff/entity for assignment to DD Waitlist
   - ☐ Other, describe: _____ _____
   - ☐ Other, describe: _____ _____
   - ☐ Other, describe: _____ _____
3. Additional follow-up needed, including assessor scheduling the assessment?
   - ❍ No ❍ Yes, describe:_____
     _____
4. Outcome (Check all that apply):
   - ☐ Assessment
   - ☐ Assessment pending documentation of Medicaid application
   - ☐ Assessment pending DD Determination completion
   - ☐ Placement on DD Waitlist
   - ☐ Information and referral only- no assessment
   - ☐ Other action, describe _____
5. Summary of contact:
   _____
   _____