Iteration 1.1 – Rev 11/05/10

A. INITIAL REQUEST FOR SERVICES
INFORMATION GATHERED BY THE CERTIFIED ASSESSOR
The Opening "Conversation" to Determine Need 100

Date of first contact: 1000 Month/Day/Year ______ 100 *(Note: system generated)*

Hi. My name is 1005 _____. 100 **What is your name?** 1010 _____ 100

Does the Person Understand English? 1012

- O **Yes** 100
- O **No** 105 The person is in need of an interpreter to communicate and move forward with the interview. Please follow lead agency policy and arrange for an interpreter.

Are you calling about yourself or someone else? 1015

- O Myself 100
- O Someone else 105 (Gather information about the "referral Source or Caller Identity")

Individual's First Name: 1020 ____________ 100
Individual's Last Name: 1025 ____________ 100
Individual's DOB: 1030 ____________ 100

Referral Source / Caller Identity 105

Referral Source*: (Verify the spelling of the name of the person who is calling)* 1000

Last Name, First Name, M.I.: ______ 100

4. **What is your relationship to the person you are calling about?** 1001

- ☐ Spouse 105
- ☐ Partner/Significant Other 107
- ☐ Son/Daughter 110
- ☐ Parent 115
- ☐ Sibling 120
- ☐ Friend 130
- ☐ Other Family 132
- ☐ Other Non-Family 133
- ☐ Neighbor 135
- ☐ Advocate 140
- ☐ Employer 142
- ☐ Attorney 143
- ☐ School 145
- ☐ Authorized Representative 147
- ☐ Another County Division 148
- ☐ Provider 150
- ☐ Health plan Coordinator 155
- ☐ Hospital/Clinic discharge professional 160
- ☐ Other Relationship 165

If any "Other " response options are selected, ***please specify:*** 1002 ______ 100

What is your title *(If calling from an agency)***?** 1003 _____ 100

What is the name and type of the organization you represent *(If applicable)*? [1005] ______ [100] **Type:** ______ [105]

If a provider/agency:

What is your mailing address? [1010]

Address: _______ [100]

City, State, Zip Code: ______ [105]

What is the telephone number where you can be reached? [1015]

○ No telephone – *skip to question 6* [100]

Home: ______ [105]
Work: ______ [110]
Cell: ______ [115]

What type of telephone services do you use? [1020]

Check all that apply:

☐ Voice only [100]
☐ TTY [105]
☐ Videophone [110]

If necessary, How do you prefer to be contacted? [1025]

○ Mail [100]
○ Telephone [105]

Determining Caller Needs[107]

7. **Can I ask how you heard about us?** [1030]

_____ [100]

Drop-down box detail:[105-360]

- 2-1-1 -AARP -Advocate -Assisted Living -Billboard -Brochure -Bus -Bus Shelter -Called before -Case Manager -Church -County - Financial Worker
-DB101 Website -DB101 Materials -DHS Line/Staff -DHS Mailing -Did Not Ask -Dining Site -Disability Linkage Line -Drug Company -Employer –
-Employment Service Provider -Flyer/Poster - Library - Mailing -Medicare --MinnesotaHelp.info - Newsletter –Newspaper -Other Agency - Other Community Setting -Other Housing Campus -Other Web Site -Pharmacy -Phone Book -Physician/Clinic -Presentation -Program HH -Promotional Item -Radio -School -Senior Center -Senior LinkAge Line -Social Security -Sporting Events -Television -Transitional Consultation Referral -Veterans Linkage Line -Vocational Rehab (VR) Web Site -Word of Mouth -Work Incentives Connection -Workforce Center

8. **Where you referred to u**

______ [100]

9. **How may I help you?** [1040]

Document the nature of the presenting concern or request: ______ [100]

☐ Abuse/Neglect [105]
☐ Accessibility/Modifications [107]
☐ Assistive Technology [110]
☐ Business Inquiry [115]
☐ Chemical Health [120]
☐ Health Services [160]
☐ Housing/Shelter [165]
☐ Individual/Family Supports [170]
☐ Legal/Advocacy [175]
☐ MA-EPD Leads [180]

- ☐ DB101 [130]
- ☐ Disaster [132]
- ☐ Donations [133]
- ☐ Education/Training [135]
- ☐ Employment/Volunteering [140]
- ☐ Financial Assistance/Management [145]
- ☐ Food [150]
- ☐ Health Insurance Counseling [155]
- ☐ Mental Health [185]
- ☐ Minnesota Help Network [190]
- ☐ Other Public Networks [195]
- ☐ Safety/Security [200]
- ☐ Social/Recreation [205]
- ☐ Transportation [210]
- ☐ Veterans [215]
- ☐ Return to Community [220]

○ The person is not requesting health and human services [225]

Department or Agency Referred to: ______ [230]

- ☐ Senior LinkAge Line® (needs basic information and assistance, Medicare or long-term care options counseling – or declines an assessment) [235]
- ☐ Disability Linkage Line® (needs basic information assistance or benefits/independent living counseling, Issues with Special Needs Basic Care Plan - Medicare –or declines an assessment) [240]
- ☐ CVSO [245]
- ☐ Other division of agency (human services related (e.g. corrections or child and family services – no long term care or assessment-related issue) [250]
- ☐ Other county division (non-human services related e.g. public health, auditor, court, law enforcement or licensing.) [255]
- ☐ Advocacy or membership organization [260]
- ☐ Other State Agency (describe ___________) [265]
- ☐ Other Federal Agency (describe ___________) [270]
- ☐ Not related to Human Services [275]
- ☐ Adult/Child Protection (emergency) [280]
- ☐ Other [285]

If other is checked, please explain: ______ [290]

10. Does the person need to be re-contacted? [1045]

○ Yes [100]
○ No [105]

Determining Need for Assessment[110]

In this section, the default is that you are speaking directly with the person who is in need of services. If you are speaking with someone else, the wording should be rephrased.

1. NAME [1000]**/ DOB** [1010]**/: __________** [100]**/__________** [100] FUNCTIONALITY – when start face to face this info is visible and validated

(*If date of birth not available, please enter estimated age)* [100]

Estimated Age Category [1015]

- ○ *Birth to 5 years* [100]
- ○ *6-16 years* [105]
- ○ *17-20 years* [110]
- ○ *21 -64 years* [115]
- ○ *65 or older* [120]

1. What is your telephone number? [1022]

○ **No telephone** – *skip to question 6* [100]

Home: ______ [105]
Work: ______ [110]

Cell: ______ [115]

2. What type of telephone services do you use? [1025]

Check all that apply:

☐ Voice only [100]
☐ TTY [105]
☐ Videophone [110]

Person's Need [115]

Note: Do not ask these questions directly. Use active listening skills and paraphrase the problem to the caller before coding the reason for the call. If necessary, ask follow-up questions to determine if an issue presents an immediate threat to an individual's health or safety. Then code the reason(s) for the call by checking any box that applies. [A full assessment into other modules should be triggered and an appointment calendaring function should be prompted if the certified assessor checks one of these boxes.]

"Safety" issue [1000]

☐ Maltreatment by another (language or criteria should match Adult and Child Protection definitions) [100]
☐ Self abuse/neglect [105]
☐ Harm to self (e.g., suicide ideations or attempts, cutting behavior) [110]
☐ Arson/Fire starter [115]
☐ Harm to others [120]
☐ Frequent history of behaviors [125]
☐ Sexual predator/offender [130]
☐ Medication mismanagement [135]
☐ Falling in home [140]
☐ Other [145]

If "Other", Explain: ______ [150]

Change in or concerns about the person's "Health" (physical, behavioral or social) [1005]

☐ Medication management concerns (includes excessive prescriptions or noncompliance or reactions, side effects, or drug interaction issues [100]
☐ Fear of Falling or a recent fall [105]
☐ Inability to manage chronic or complicated condition [110]
☐ Not eating/weight loss [115]
☐ Needs assistance with daily living because of extreme frailty [120]
☐ Need for intensive palliative care [125]
☐ Direct Care Services or supervision is required during day or night [130]
☐ Health episodes come at unpredictable times of the day or night [135]
☐ Other [140]

If "Other", Explain: ______ [145]

Change in or concerns about the person's "Status" physical, behavioral or social situation that may put the person at risk [1010]

☐ Mental Health or Development Disability Services Needs [review ORBA 1 requirements and either remove this or keep it] [100]
☐ Physical status or functioning [105]
☐ Competencies at home, school, or community [110]
☐ Cognitive/Memory issues [115]
☐ Change in living environment or loss of housing (includes move to or from an assisted living or community based housing setting that serves people who are in need of specialized services) [120]
☐ Discharge from a correctional facility and has chronic or co morbid conditions [125]
☐ Recurring substance abuse episodes [130]

☐ Other [135]

If "Other", Explain: ______ [140]

"Status" Change in the person's family or financial situation resulting in risk to individual or caregiver availability, including loss of home, or access to adequate care and nutrition or displacement. [1015]

☐ Availability of caregiver to provide care - may include temporary or permanent loss of family caregiver (6 months or less) [100]
☐ Substantial change in finances of family or individual [105]
☐ Caregiver serving in military which may result in absence [110]
☐ Caregiver has extended illness [115]
☐ Death of caregiver, divorce, or other long term change [120]
☐ Caregiver strain [125]
☐ Caregiver expresses need for respite [130]
☐ Other [135]

If "Other", Explain: ______ [140]

Caller is requesting "supports" [1020]

☐ Current services not adequate to help me remain in my home (e.g. personal care, chore, homemaker) [100]
☐ Disabled and would like to work [102]
☐ Habilitation (skill training and enhancement) [105]
☐ Social or community supports [110]
☐ Home-delivered Meals [115]
☐ Transportation to long-term care services [120]
☐ Personal Emergency Response Systems [125]
☐ Environmental adaptations or supports or home modifications [130]
☐ Personal adaptive equipment [135]
☐ Deaf/Blind support [140]
☐ Other [145]

If "Other", Explain: ______ [150]

The person needs "School" support or evaluation [1025]

☐ Poor school performance [100]
☐ Behavior issues [105]
☐ Truancy [110]
☐ Early Childhood Evaluation [115]
☐ Transition support from child to adult [120]
☐ Other [125]

If "Other", Explain: ______ [130]

Change in "Setting" or is in need of level of care determination [1030]

☐ Relocation to community [100]
☐ Reassessment requested [if this is checked, it should prompt the PAS work path.] [105]
☐ Reassessment required [110]
☐ Health Care Professional requesting nursing facility admission-preadmission screening required [This should prompt opening up the PAS work path.] [115]
☐ Admission to a Neuro-Behavioral Hospital [120]
☐ Other [125]

If "Other", Explain: ______ [130]

The person has "Sanctions"/ Legal issues 1035

- ☐ Recurring criminal/legal issues 100
- ☐ Discharge from prison/jail 105
- ☐ Other 110

If "Other", Explain: ______ 115

☐ **Person requests an assessment** 1040 100

IF AN ASSESSMENT IS REQUIRED/REQUESTED:

Set up Appointment and gather additional information about person needing services 120 (

Note: some information you may want to look up in the system and validate when the face to face assessment is completed. If this is a new individual you may want to gather this information now.)

Date of Initial Call/Contact: 1000 Month/Day/Year ______ 100 (Note: system generated)

If the person will require comprehensive intake, the following "script" can be used to provide a brief overview of the reason that "personal" intake questions are required in the next section below.

Based on what you have told me, I would like to set up a time to meet with you to complete a more thorough assessment. The whole assessment might take us 1 to 2 hours to complete. If you need services and supports, the assessment will help us develop a plan that works for you. Is that something that you would be interested in? 1005

- O Yes 100
- O No 105

If yes and this is an initial assessment, state:, **When I meet with you in your home, I will need to ask you questions to help me get to know you better, such as your age, where you live, if you have a job, how much money you make, and information about any medical conditions that you might have, things about your personal history, your wants and needs, etc. Are you okay with me asking these questions when we meet?**

SOCIAL SECURITY NUMBER 1007**/** __________ 100

2. **PMI Number** *(8 digits)*: 1010

   ______ 100

   O No PMI Number assigned 105

Communication Assistance 125

1. *Is it apparent that the person speaks English?* 1000

   - O Yes 100
   - O No 105

   Comments: ______ 110

2. *Does the person appear to understand English?* 1005

   - O Yes 100
   - O No 105

   If yes to either of the above questions, skip questions 3-9.

Comments: ______ 110

3. *Would an interpreter of any kind (to translate from another language, to use sign language, etc.) be helpful in getting accurate information?* 1010

- Yes 100
- No – *skip to question 6* 105

Comments: ______ 110

4. Do you have another language that you prefer to use other than English? 1015

- Yes - **What is your preferred language?** ______ 100
- No 105

Comments: ______ 110

5. Would you like to have an interpreter help you? 1020

- No 100
- Yes 105

Comments: ______ 110

6. Do you prefer written materials in a language other than English? 1025

- Yes – **specify:** ______ 100
- No – *skip to question 8* 105

Comments: ______ 110

7. Is there a particular format in which you would like these written materials? 1030

- No 100
- Yes - *select one of the options, below:* 105
  - Large print: ______ font size 110
  - Braille 115
  - Electronic format – *program or file type:* ______ 120

Comments: ______ 125

8. *Does the person to be interviewed use some form of sign language to communicate*? 1035

- No - *skip question 9* 100
- Yes - ***indicate what type:*** 105

Check all that apply:

- ☐ American Sign Language 110
- ☐ International Sign Language 112
- ☐ Signed English 115
- ☐ Baby Sign 120
- ☐ Home Signs, Gestures 125
- ☐ Manual alphabet (finger spelling) 130
- ☐ Limited or Close Vision Signing 135
- ☐ Tactile (hand in hand) Signing 140
- ☐ Emoticon + Bodicon (facial expression + body language) 145
- ☐ Other – describe: ______ 147

Comments: ______ [150]

9. Does the person to be assessed need any additional accommodations? [1040]

- ○ No [100]
- ○ Yes - ***indicate what type:*** ______ [105]

Substitute Decision-Maker Status [127]

1. Does someone have the legal authority to make decisions or sign papers for you? [1000]

- ○ Yes [100]
- ○ No – *skip to the next section of this module* [105]
- ○ Unsure [110]

2. *Obtain the following contact information on substitute decision-maker:* [1005]

Last Name, First Name, M.I.: ______ [100]

Address: ______ [105]

City, State, Zip Code: ______ [110]

Telephone Numbers [1006]

- ○ No telephone [100]

Home: ______ [105]
Work: ______ [110]
Cell: ______ [115]

Telephone Services Used: [1007]

Check all that apply:

- ☐ Voice only [120]
- ☐ TTY [125]
- ☐ Videophone [130]

Substitute decision maker's preferred way to be contacted: [1009]

- ○ Mail [100]
- ○ Telephone [115]

3. What is this person's relationship to you? [1010]

- ☐ Spouse [100]
- ☐ Parent [103]
- ☐ Partner/Significant Other [105]
- ☐ Sibling [110]
- ☐ Friend [115]
- ☐ Son/daughter [120]
- ☐ Grandchild [125]
- ☐ Other family/friend [127]
- ☐ Neighbor [129]
- ☐ Person Paid to Help [130]
- ☐ Private paid guardian [132]
- ☐ Other Relationship [135]

Comments: ______ [140]

4. *If there is a second substitute decision-maker, please complete this section. If not, skip to question 6.* [1015]

Last Name, First Name, M.I.: ______ [100]

Address: ______ [105]

City, State, Zip Code: ______ [110]

Telephone Numbers [1016]

○ No telephone [100]

Home: ______ [105]
Work: ______ [110]
Cell: ______ [115]

Telephone Services Used: [1017]

Check all that apply:

☐ Voice only [120]
☐ TTY [125]
☐ Videophone [130]

Substitute decision maker's preferred way to be contacted: [1019]

○ Mail [100]
○ Telephone [115]

5. What is this person's relationship to you? [1020]

☐ Spouse [100]
☐ Parent [103]
☐ Partner/Significant Other [105]
☐ Sibling [110]
☐ Friend [115]
☐ Son/daughter [120]
☐ Grandchild [125]
☐ Other family/friend [127]
☐ Neighbor [129]
☐ Person Paid to Help [130]
☐ Private paid guardian [132]
☐ Other Relationship [135]

Comments: ______ [140]

6. Who can we contact if we cannot reach the substitute decision-maker? [1025]

Last Name, First Name, M.I.: ______ [100]

Address: ______ [105]

City, State, Zip Code: ______ [110]

Telephone Numbers [1026]

○ No telephone [100]

Home: ______ [105]
Work: ______ [110]
Cell: ______ [115]

Telephone services used: [1027]

Check all that apply:

☐ Voice only [120]
☐ TTY [125]

☐ Videophone [130]

Alternative Contact's preferred way to be contacted: [1029]

- Mail [100]
- Telephone [115]

7. What is this person's relationship to you? [1030]

☐ Spouse [100]
☐ Parent [103]
☐ Partner/Significant Other [105]
☐ Sibling [110]
☐ Friend [115]
☐ Son/daughter [120]
☐ Grandchild [125]
☐ Other family/friend [127]
☐ Neighbor [129]
☐ Person Paid to Help [130]
☐ Private paid guardian [132]
☐ Other Relationship [135]

Comments: ______ [140]

Demographics *(If the record can be located, verify all demographic and service-related information that appears in the system)* [135]

3. Gender: [1005] Male [100] Female [105]

4. What is your address? [1010]

Address: ______ [100]

City, State, Zip Code: ______ [105]

- Homeless [110]

Is this your permanent address? [1012]

- Yes – *skip to question 3* [100]
- No - **What is your permanent address?** [105]

Address: ______ [110]

City, State, Zip Code: ______ [115]

5. Is your mailing address the same as where you are living? [1015]

- Yes – *skip to question 4* [100]
- No - **What is your mailing address?** [105]

Address: ______ [110]

City, State, Zip Code: ______ [115]

How do you prefer to be contacted? [1032]

- Mail [100]
- Telephone [115]

6. County of Residence: [1035] ______ [100]

7. **County of Financial Responsibility:** [1040] ______ [100]

8. **County of Service:** [1045] ______ [100] *(This is the County where the financial case is maintained)*

9. **What is your current marital status**? [1055]

- ☐ Single/Never Been Married [102]
- ☐ Married [105]
- ☐ Partner/Significant Other [110]
- ☐ Widowed [115]
- ☐ Separated [120]
- ☐ Divorced [125]
- ☐ Common Law Marriage in another State [130]

HOUSING TYPE AND PROGRAM LICENSE AT TIME OF ASSESSMENT [1057]

Person's Current Housing Type	Current Program License Allowed by Housing Type (Current or Planned)
☐ Homeless [100]	None
☐ ICF/MR including RTC [105]	ICF/MR
☐ Hospital [110]	None
☐ Board & Lodge [115]	Housing with Services, Class A Housing with Services, Class F None
☐ Adult Foster Care [120]	Foster care, corporate Foster care, family Housing with Services, Class A Housing with Services, Class F
☐ Own Home, Apartment [125]	Housing with Services, Class A (If this is a registered Housing with Services setting) Housing with Services, Class F (If this is a registered Housing with Services setting) None
☐ Nursing Facility or Certified Boarding Care [130]	Nursing facility
☐ Noncertified Boarding Care [135]	Housing with Services, Class A Housing with Services, Class F None
☐ Correctional facility [137]	None

☐ **Other** [140]

***If "Other"*, specify:** ______ [145]

Type of housing: [1058]

○ Temporary [100] ○ Permanent [105]

10. **Who are you currently living with?** [1060]

- ☐ Lives Alone [102]

- ☐ Spouse [105]
- ☐ Children [110]
- ☐ Other Family/ Friends [115]
- ☐ Parent(s) [135]
- ☐ Group setting with non relatives [140]
- ☐ Foster Parents [145]
- ☐ Roommates [147]

11. [If this is a child/person under 26 as of the date of the interview, please asked the following question]

Are either of the parents a U.S. Veteran? [1065]

- ○ No – *skip to question 16*[105]
- ○ Yes [110]

If yes, was either parent ever deployed/participate in active duty? [1070]

- ○ No [100]
- ○ Yes [105] *If yes, check one or more below*
  - ○ Spanish-American War. 21 Apr 1898 – 4 Jul 1902 [110]
  - ○ Mexican Border: 09 May 1916 – 05 Apr 1917 [115]
  - ○ World War I: 06 Apr 1917 – 11 Nov 1918 [120]
  - ○ Service in Russia: 1 day of service before 12 Nov 1918 and served after 11 Nov 1918 and before 2 Jul 1921 [125]
  - ○ World War II: 07 Dec 1941 – 31 Dec 1946 [130]
  - ○ Korean War: 27 Jun 1950 – 31 Jan 1955 [135]
  - ○ Vietnam War: 05 Aug 1964 – 07 May 1975 [140]
  - ○ Persian Gulf: 02 Aug 1990 – TBA [145]

12. Are you or your spouse a U.S. Veteran? [1075]

- ○ No – *skip to question 16*[105]
- ○ Yes [110]

13. Were you ever deployed/participate in active duty? [1080]

- ○ No [105]
- ○ Yes [110] *If yes, check one or more below*
  - ○ Spanish-American War. 21 Apr 1898 – 4 Jul 1902 [115]
  - ○ Mexican Border: 09 May 1916 – 05 Apr 1917 [120]
  - ○ World War I: 06 Apr 1917 – 11 Nov 1918 [125]
  - ○ Service in Russia: 1 day of service before 12 Nov 1918 and served after 11 Nov 1918 and before 2 Jul 1921 [130]
  - ○ World War II: 07 Dec 1941 – 31 Dec 1946 [135]
  - ○ Korean War: 27 Jun 1950 – 31 Jan 1955 [140]
  - ○ Vietnam War: 05 Aug 1964 – 07 May 1975 [145]
  - ○ Persian Gulf: 02 Aug 1990 – TBA [150]

14. Did you engage in combat? [1085]

- ○ No [105]
- ○ Yes [110]

15. Are you of Spanish/ Hispanic/ Latino descent? [1090]

- ○ No [105]
- ○ Yes [110]

16. **What is your race?** [1095] *(This is identified by the person. More than one race can be reported)*:

- ☐ White [105]
- ☐ Black or African American [110]
- ☐ American Indian or Alaskan Native: [115]
  - Tribal affiliation: Click here to enter text. [117]
- ☐ Asian – **specify: ______** [120]
- ☐ Pacific Islander: [125]
  - ☐ Native Hawaiian [130]
  - ☐ Guamanian or Chamorro [135]
  - ☐ Samoan [140]
  - ☐ Other Pacific Islander – **specify: ______** [142]
- ☐ Some other race – **specify: ______** [150]

Disability Certification [140]

1. **Are you certified as having a disability?** [1000]
   - ○ Yes [100]
   - ○ No – *skip question 2* [105]
   - ○ Unsure – *skip question 2* [110]
   - ○ Certification pending [115]

2. **Type of Certification:** [1005]
   - ○ SMRT – ***specify "certified through" date***: Month/Day/Year [100]
   - ○ SSA [105]
   - ○ Unsure – *case manager to confirm certification type* [110]

Health Insurance Information [145]

1. **Do you currently have health insurance coverage?** [1000] (*or, verify information in system)*
   - ○ Yes [100]
   - ○ No – *skip to question 4* [105]

2. **What type of health or long-term care coverage do you have?** [1005]
   - ☐ TEFRA [100]
   - ☐ Medical Assistance [105]
   - ☐ Privately Purchased Insurance [110]
   - ☐ Employer Provided Insurance [115]
   - ☐ VA [120]
   - ☐ Minnesota Care [125]
   - ☐ Health care coverage pending approval [130]
   - ☐ Other [135]

   Please list policy numbers and effective dates, if available. [1007]

   - ☐ Medical Assistance Health Care (MA): [100]
   - ☐ Medical Assistance Employed Persons with Disabilities - Effective Dates: ______ [105]
   - ☐ Emergency Medical Assistance - Effective Dates: ______ [110]
   - ☐ Program HH - Effective Dates: ______ [115]
   - ☐ Program IM- Effective Dates: ______ [120]
   - ☐ Non Citizen Medical Assistance - Program NM - Effective Dates: ______ [125]
   - ☐ Minnesota Senior Care Plus (MSC+) - Effective Dates: ______ [130]
   - ☐ Minnesota Senior Health Options- Effective Dates: ______ [135]
   - ☐ PMAP - Effective Dates: ______ [140]
   - ☐ Emergency Medical Assistance - Effective Dates: ______ [145]

☐ Medicare Savings Programs (QMB, SLMB, QI) - Effective Dates: ______ 150
☐ Medicare - Policy Number: _______ 155
  ☐ Medicare Part A - Effective Dates: _______ 160
  ☐ Medicare Part B - Effective Dates: _______ 165
  ☐ Medicare Part D - Effective Dates: ______ 170
    ☐ Low Income Subsidy- Effective Dates: ______ 175
  ☐ Medicare Special Needs Basic Care – Effective Dates: ______ 180
  ☐ Medicare Advantage Plan - Effective Dates: _______ 185
  ☐ Medicare Supplement - Effective Dates: ______ 195
☐ MinnesotaCare: ______ 200
  ☐ SCHIP: _______ 205
  ☐ PMAP: _______ 210
☐ Private: _______ 215
  ☐ HMO: _______ 220
  ☐ PPO: _______ 225

☐ Employer Retiree Health Plan: _______ 230
☐ Employer provided Health: ______ 235

☐ MN Health Care Program Card for GAMC: _______ 240
☐ Veterans Administration: _______ 245
☐ LTC insurance Policy: ______ 250
    ☐ Has Partnership Certification: ______ 255
    ☐ Group Policy – Not Partnership: ______ 260
    ☐ Individual – Not Partnership: ______ 265

☐ Self-Insurance: ______ 270
☐ Other: ______ 275
☐ Other: ______ 280
☐ Other: ______ 285

Is the health coverage in your name? 1010

O Yes 100
O No – **Whose name is the insurance under?** ______ 105

Do you have your insurance card with you? 1012

O Yes 100 **Insurance Type?** ______ 102
  Plan/Policy Number? ______ 103
  Effective Dates? ______ 104

O No 105

3. **Do you need help paying for medications/drugs?** 1015

O Yes 100
O No 105

4. **Are your medical needs being met by your insurer (e.g. getting wheelchairs, medical supplies, long term care insurance, etc.)?** 1025

O Yes 100

- No – **explain:** ______ [105]

5. **Do you need help paying for your health care?** [1030]

- Yes – **specify:** ______ [100]
- No [105]

6. **Would you like assistance obtaining/maintaining Medical Assistance?** [1035]

- Yes [100]
- No [105]

Appointment Scheduler [150]

Thank you for the information you provided. It will help us prepare before we come to visit with you. Now, I need to schedule the face to face visit with you now: What are some dates you have available: [1000] [100]

Calendaring function should open:

1. Initial Assessment Visit Assigned To: [List of certified assessors should display with check box based on available authenticated users for lead agency]
2. Special Instructions for Initial Assessment Visit (include accommodations needed): [e.g. daughter will meet you at the back door. Knock twice… Or…. Has a dog. This should also prompt arrangement for an interpreter.]
3. Date of Initial Assessment Visit:
4. Date of Assessment Visit Follow-Up, if needed:
5. Date Satisfaction Survey Sent:

REASON FOR ASSESSMENT [1020]

- Initial assessment [100]
  Health Risk Assessment (for MCOs)
- Annual Assessment [105]
  Health Risk Assessment (for MCOs)
- Assessment due to a significant change in status [110]
- Waiver Assessment for 65th birthday [115]
- Change in guardianship status [120]
- Case Management Update [125]

Location of Assessment [1025]

- ☐ Conducted by phone (as allowed by law) [100]
- ☐ Person's Home [105]
- ☐ Person's Place of Work [110]
- ☐ School [115]
- ☐ Community [120]
- ☐ Hospital [125]
- ☐ Nursing Facility [130]
- ☐ Correctional Facility [135]
- ☐ ICF/MR [140]
- ☐ Agency/County Office_ [145]

☐ Other [150]

If "Other", specify: ______ [155]

Name of Screener / Intake Worker completing First Contact Interview/Intake: ______ [155, 1000, 100]

Date(s): Month/Day/Year ______ [1005, 100]