|  |  |
| --- | --- |
| **Provider (Caller) Name and Contact #:** | **Name of Provider / CRSP:****:** |
| **Today’s Date:** | **LOC: Emergent Urgent Routine** |
| **Requested enrollment date:** | **MichiCANS Score (if applicable):**  |
| **Access Call Center Representative Name:** | **Consumer’s Name Date of Birth** |

**Intellectual / Developmental Disability (DD) Eligibility Checklist**

**(This form must be accompanied by CRSP enrollment Form)**

**\*\* Please include any supporting documentation (IEP, Psychological Evaluation, Functional Assessment, Etc.)**

**ONLY Children Services Special Population Screening documents are to be submitted via smartsheet form:**

<https://app.smartsheet.com/b/form/336965fa2885435db00b594e4f173251>

1. Does the person have a DSM-IV Diagnosis that indicates a Developmental Disability?

**[ ]  Yes. What is the code?**

**[ ]  No. Inform the provider that the person MUST have a Diagnosis.**

1. Is the person a Wayne County Resident?

**[ ]  Yes. Type of proof received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?**

**[ ]  City of Detroit Resident**

**[ ]  Out of Detroit (including Highland Park & Hamtramck) City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  No. Referred to appropriate county of residence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  Yes. Declared as “Homeless” at Wayne County ER/Crisis Facility**

1. Does the person have insurance? \_\_\_\_\_\_\_ Yes. What Type?

**[ ]  Medicaid: Name of QHP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  Medicare: What parts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  Commercial Insurance; what type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  MI Child of Michigan; Name of HMO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]  Self-Pay**

**[ ]  No. Uninsured**

**[ ]  Other System Involvement (Substance Abuse, Juvenile Justice and/or Special School Services) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For persons age 5 or under**

Does the person have a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability if services are not provided?

 **Yes (The person is eligible)**

 **No (The person is not eligible)**

**For persons over the age of 5:**

1. Is the person older than five and have ***all*** of the following:

**[ ]  Mental and/or physical impairment**

**[ ]  Impairment prior to age 22**

**[ ]  Impairment likely to continue indefinitely**

1. Functional limitation in 3 or more of the following:

**[ ]  Self care**

**[ ]  Receptive/expressive language**

**[ ]  Learning**

**[ ]  Mobility**

**[ ]  Self-Direction**

**[ ]  Economic Self-Sufficiency**

**[ ]  Capacity for independent living**

1. Does the person require lifelong or extended need for care, treatment, or services, which are individually planned and coordinated?

**[ ]  Yes (Eligible)**

**[ ]  No (Not eligible)**

1. Comments/notes/Presenting Problem / Reason for enrollment: