|  |  |
| --- | --- |
| **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: