



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

Request for Assessment of Need for Clinical Services

General Information	NAME OF INDIVIDUAL TO BE ASSESSED:		PCP ANNIVERSARY DATE:	TODAY'S DATE:
	IS INDIVIDUAL ABLE TO ANSWER QUESTIONS ON THEIR OWN BEHALF? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	ENTER COMMENTS BELOW: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		REASON FOR REFERRAL:	DESIRED SERVICE START DATE:
	DATE OF BIRTH:	MCI#:	COUNTY OF RESIDENCE:	
	ICD 10 CODE:			
	INDIVIDUAL'S PHONE NUMBER:			
Assessment Requested	TYPE OF ASSESSMENT Choose an item.		<i>IF YOU ARE REQUESTING A BA AND AN RN ASSESSMENT, PLEASE COMPLETE/SUBMIT A SEPARATE FORM FOR EACH REQUEST.</i>	
	HAS THIS PERSON BEEN ASSESSED BEFORE? Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>		ENTER COMMENTS BELOW: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	
Provider Information	CURRENT PROVIDER AND AGENCY (IF APPLICABLE):			
	NEW PROVIDER IF THIS REQUEST IS TO CHANGE PROVIDERS:			
Legal Guardian Information	DOES THE INDIVIDUAL HAVE A LEGAL GUARDIAN? Yes <input type="checkbox"/> No <input type="checkbox"/>		NAME OF LEGAL GUARDIAN:	
	RELATIONSHIP TO INDIVIDUAL:			
	EMAIL ADDRESS:		TELEPHONE NUMBER:	
Primary Caregiver/ Additional Contact Information	PLEASE PROVIDE NAME OF AN AGREED UPON ALTERNATIVE CONTACT PERSON TO ANSWER QUESTIONS ABOUT INDIVIDUAL'S BEHAVIOR/MENTAL HEALTH/MEDICAL ISSUES, IF APPROPRIATE:			
	CONTACT PERSON'S NAME:		RELATIONSHIP TO INDIVIDUAL:	
	EMAIL ADDRESS:		TELEPHONE NUMBER:	

Funding Information	HOW WILL THIS SERVICE BE FUNDED: Choose an item.	LIFESPAN WAIVER SUBMISSION DATE:
		LIFESPAN WAIVER APPROVAL DATE:
	ENTER COMMENTS BELOW: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	

Case Manager/Community Navigator Information	CM/CN SUBMITTING THIS REQUEST:	
	CM/CN EMAIL ADDRESS:	CM/CN TELEPHONE NUMBER:
	HAS CM/CN CONFIRMED INDIVIDUAL/GUARDIAN/FAMILY AGREEMENT TO SERVICE? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>IF NO, DO NOT SEND THIS REQUEST PRIOR TO OBTAINING CONSENT FROM THE INDIVIDUAL/GUARDIAN.</i>	
	DATE CM/CN SPOKE TO INDIVIDUAL/GUARDIAN/FAMILY:	VIA PHONE OR EMAIL:

