

LEVEL I SCREEN

**PLEASE READ THE INSTRUCTIONS ON THE SECOND PAGE OF THIS FORM FOR DETAILS.
HISTORY & PHYSICAL AND LIST OF MEDICATIONS MUST BE INCLUDED WITH THIS FAX.**

FAX NUMBER: 1-800-413-3890/443-4585

TELEPHONE NUMBER.: 1-800-219-7035/443-0320

Individual's Name _____	SSN _____	Date of Birth _____
Diagnosis Primary _____	Physician _____	
Secondary _____	Provider _____	
Other _____	City _____	

Is there a current H & P Yes No If no, call Foundation for instructions.

A. MENTAL ILLNESS		YES	NO
1.	Does the individual have a diagnosis of serious mental illness (MI)? Diagnosis _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	Does the individual have any indications of a mental illness? If yes, describe. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	If the individual has a diagnosis or indications of mental illness, does the individual have a primary diagnosis of dementia? _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is the individual on antipsychotic medication? If yes, what is individual's a) current mental status; b) reason for medications; c) length of time on medications. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is individual on an antidepressant? If yes, indicate a) history of depression; b) length of depression; c) current depressive status; d) whether depression is situational due to circumstances. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

B. MENTAL RETARDATION OR RELATED CONDITIONS		YES	NO
1.	Does the individual have a diagnosis of mental retardation (MR)?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Does the individual have a diagnosis of a related condition (cerebral palsy, autism, seizures, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has the individual ever been referred to or served by an agency/institution serving individuals with mental retardation or related conditions?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does the individual have any indications of mental retardation or a related condition?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Does the individual have a brain injury? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

C. INFORMATION SOURCE	
The above information has been provided by: Name _____ Date _____	
Agency _____	Phone No. _____ Fax No. _____

FOR FOUNDATION USE ONLY

D. APPROVED	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Referral for Level II	<input type="checkbox"/> MI	<input type="checkbox"/> MR	<input type="checkbox"/> MI/MR
MR Referral made to: _____	Date _____		
MI Referral made to: _____	Date _____		
Comments: _____ _____			
Name: _____	Date _____		

INSTRUCTIONS:

- A. Serious mental illness means that the individual is diagnosed according to the criteria specified in DSM-IV as having one of the following conditions: schizophrenia, paranoia, major affective disorder, schizo affective disorder, or atypical psychosis, and does not have a primary diagnoses of dementia, including Alzheimer's disease or a related disorder, which is based on a neurological assessment;

and as a result of the diagnosed mental condition, the individual presently suffers from significant impairment in at least two of the following functional areas:

1. ability to meet appropriate vocational or homemaker roles for the applicant's current stage of life;
2. ability to maintain community living without dependence on public support systems and monitoring;
3. ability to develop and maintain individual relationships and support systems;
4. ability to meet the normal demands of community living, including self help and self maintenance, freedom of movement, and engaging in a stage-of-life appropriate range of activities;

Indications of mental illness include delusions, hallucinations, incoherence or marked loosening of associations, flat or inappropriate affect, long-standing depressed mood, feelings of worthlessness, excessive or inappropriate guilt, recurrent suicide attempts or ideation, behavior which inflicts injury on self or others, or behavior which presents an imminent threat to self or others.

- B. Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related conditions means severe, chronic disabilities attributable to cerebral palsy, epilepsy, autism or any other condition, other than mental illness, found to be closely related to MR because the condition results in impairment of general intellectual function or adaptive behavior similar to that of individuals with MR and requires treatment or services similar to those required by these individuals. It is manifested before the individual reaches age 22, is likely to continue indefinitely and it results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

- C. Self-explanatory.
- D. Do not fill out. For Mountain Pacific Quality Health (MPQH) use only.
- E. Do not fill out. For Mountain Pacific Quality Health (MPQH) use only.

LEVEL OF CARE INSTRUCTIONS:

A Level of Care determination is required prior to Medicaid making payment to a nursing facility or the Home and Community Based Services Program (waiver). Any individual currently eligible, applying, or who intends to apply for Medicaid needs to request a determination. **Submit the AMDD-86 (Level of Care Determination) with at least identifying information via fax or telephone to Mountain Pacific Quality Health.** MPQH will notify the applicant, referral source and county Office of Human Services of the results.