

Individual Name:

Medicaid ID:

INITIAL ASSESSMENT  
FORM# 650.E

Date: \_\_\_\_\_

- 1. Diagnosis:
  
- 2. Presenting needs (type of placement, current presenting problems):

Psychiatric Needs/Problems:  Yes                       No  
If yes, complete the chart below:

Need/Problem	Onset	Duration

Support Needs/Problem:  Yes                       No  
If yes, explain:

Need/Problem	Onset	Duration

Individual Name:

Medicaid ID:


**3. Current medical problems**

*i.e. physical health, dental and recent physical complaints) (For each condition, in the last 8 columns, check all categories that apply)*

4.	List current medical diseases & conditions	Name of Treating Physician	Onset	Duration	Stable with tx	Unstable with tx	Not treated /unmet need	Refuses tx	Compliant with tx	Self-managing	Communicable Disease	Chro

Current medications (Use additional paper as needed)

**Non-prescription medications**

Medication	Dosage	Frequency	Provider	Side Effects	Describe Level of Effectiveness

Individual Name:

Medicaid ID:


**Prescription medications** (*Medical and Psychiatric*)

Medication	Dosage	Frequency	Provider	Side Effects	Describe Level of Effectiveness

5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders

Yes       No

If yes, explain:

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Individual Name:

Medicaid ID:

\_\_\_\_\_

Need/Problem	Onset	Duration

6. At risk behavior to self and others:

Yes       No

If yes, explain:

\_\_\_\_\_

\_\_\_\_\_

Need/Problem	Onset	Duration

Individual Name:

Medicaid ID:

Based on this initial assessment does the individual meet criteria for admission with Golden Rule Care under the ID/DD Waiver? If yes, the initial plan must be developed no later than 24 hours after admission.

Yes       No

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Program Director/QDDP Name

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Date

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Program Director/QDDP Signature and Title