

Clark Quality Care, LLC

Initial Assessment – FORM 650.E

Individual Information

- **Individual Name:** _____
 - **Date of Birth:** _____
 - **Medicaid ID:** _____
 - **Date of Assessment:** _____
-

1. Diagnosis

Primary Diagnosis: _____

Secondary Diagnoses (if applicable): _____

2. Presenting Needs

(Type of placement and current presenting problems)

Psychiatric Needs/Problems: Yes No

If yes, describe (include onset and duration):

Support Needs/Problems: Yes No

If yes, describe (include onset and duration):

3. Current Medical Problems

(Include physical health, dental needs, and recent complaints)

4. Current Medications

Prescription Medications (Medical & Psychiatric)

Medication Name | Dosage | Frequency | Prescribing Provider | Side Effects | Effectiveness

Non-Prescription Medications

Medication Name | Dosage | Frequency | Provider (if applicable) | Side Effects

5. Substance Use History

(Current and past substance use or co-occurring disorders)

Yes No

If yes, describe (include onset and duration):

6. Risk Behaviors (Self/Others)

Yes No

If yes, describe (include onset and duration):

7. Admission Determination

Based on this initial assessment, does the individual meet criteria for admission?

Yes No

If yes, an **Initial Plan must be developed within 24 hours of admission** in accordance with DBHDS requirements.

Authorization

- **Program Director/QDDP Name:** _____
- **Signature:** _____
- **Date:** _____