1. **Date request submitted:** Click to enter date
2. **Reason for assessment request** (select one main category only):

[ ]  New to Waiver

[ ]  Training Center Post Discharge— 3–6 month review (Optional and only if needed)

1. **Type of assessment being requested** (select one):

[ ]  Child (ages 5–15) [ ]  Adult (ages 16 and over)

1. **What is the likely location of the interview?**

|  |  |
| --- | --- |
| **Location Name:**       | **Agency:**       |
| **Address***:*       | **Phone #***:*       |
| **City:**       | **State:**       | **Zip***:*       |
| **County Name:**       |
| **Location Type:**       |

**5. Will the individual require an interpreter for the SIS® Interviewer?** Choose an item

**Interpreter Language:**

**6**. **Will the individual require other accommodations to participate in the SIS® interview?** Choose an item

**Other accommodations descriptions:**

1. **Was this request reviewed by your CSB SIS® Administrator** (select one)? [ ]  Yes [ ]  No
2. **Individual’s Information:**

|  |  |  |
| --- | --- | --- |
| **Name:**       | **Address:**  | **Date of Birth:**       |
| **CSB Tracking: #**  | **SSN:**       | **Medicaid: #**  |
| **ISP Dates:**      **to**       | **Date of Last SIS® (if completed by TC):**      | **SIS® ID Number (if completed by TC):**      |

1. **Support Coordinator/Case Manager Information (ONLY ENTER INFO HERE):**

|  |  |
| --- | --- |
| **Name:**       | **Agency:**       |
| **Phone: #**      | **Phone: #**       |
| **Email Address:**       |
| **Has SC/CM known Individual for 3 months?** Choose an item |

1. **Enter a new Respondent: If Individual has a Guardian they must be entered as a Respondent.**

|  |  |  |
| --- | --- | --- |
| **Respondent:**  | **Respondent Type:** Choose anitem | **Type of Service:** Choose an item |
| **Relationship: Guardian** | **How long has Respondent known Individual?** Choose an item | **Direct Contact Hours over past 3 months:** Choose an item |
| **Phone: #** | **Email:**  | **Does the Respondent Reside with the Individual: [ ]  Yes [ ]  No** |
| **Address (number street, city, state, zip):**       |
| **Respondent:**       | **Respondent Type:** Choose an item | **Type of Service:** Choose an item |
| **Relationship:** Choose an item | **How long has Respondent known Individual?** Choose an item | **Direct Contact Hours over past 3 months:** Choose an item |
| **Phone: #**      | **Email:**       | **Does the Respondent Reside with the Individual:** **[ ]  Yes** **[ ]  No** |
| **Address (number street, city, state, zip):**  |
| **Respondent:**       | **Respondent Type:** Choose an item | **Type of Service:** Choose an item |
| **Relationship:** Choose an item | **How long has Respondent known Individual?** Choose an item | **Direct Contact Hours over past 3 months:** Choose an item |
| **Phone: #**      | **Email:**       | **Does the Respondent Reside with the Individual: [ ]  Yes [ ]  No** |
| **Address (number street, city, state, zip):**  |
| **Respondent:**       | **Respondent Type:** Choose an item | **Type of Service:** Choose an item |
| **Relationship:** Choose an item | **How long has Respondent known Individual:** Choose an item | **Direct Contact Hours over past 3 months:** Choose an item |
| **Phone #***:*       | **Email:**       | **Does the Respondent Reside with the Individual: [ ]  Yes [ ]  No** |
| **Address (number street, city, state, zip):**  |
| **General Notes:**  |

|  |
| --- |
| **—SECTION BELOW FOR DDS USE ONLY—** |
| 1. **Date Request Received:** Click to enter date
2. **SIS® to be Completed By:** Click here to enter a date
3. **Date of DDS Review:** Click to enter date
4. **Outcome:** [ ]  Approved [ ]  Denied
5. **Notes:** Click here to enter text
6. **DDS Reviewer Name/Title:**
 |

|  |
| --- |
| **—SECTION BELOW FOR ASCEND USE ONLY—** |
| 1. **Date Request Received:** Click to enter date **Time Request Received:** Click to enter text
 |