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 |