State of Illinois
Department of Healthcare and Family Services

Interagency Certification Of Screening Results

Name: _____ Birth Date:

Address: _____ Social Security #: _____

_____ Medicaid Eligible: Y ☐ or N ☐

Facility Name: _____ Case #, if known: _____

Address: _____ Recipient #, if known: _____

_____

Date of screening: _____ Determination of Need Score: _____

NOTE: Screening is valid for 90 days from date of screening.

Date of admission to facility: _____

Admission to nursing facility or supportive living facility occurred prior to the date of screening and one of the following circumstances existed:

☐ Placed from out-of-state; or

☐ Hospital Emergency/Outpatient Services; or

☐ Pre-existing condition of need for a caregiver and caregiver is no longer able to provide care.

Explain reason for loss of caregiver (must be completed):

The individual was screened to determine his/her need for nursing facility, supportive living or ICF/DD services and to ascertain if other services might be an acceptable alternative to nursing facility, supportive living or ICF/DD placement.

☐ Screening indicated supportive living services are appropriate.

☐ Screening indicated ICF/DD services are appropriate.

☐ Screening indicated nursing facility services are appropriate.

☐ Screening indicated nursing facility, supportive living or ICF/DD services are not appropriate.

SCREENING CERTIFIED BY:

☐ Department on Aging

☐ Department of Human Services Check One:

☐ Division of Rehabilitation Services ☐ Division of Developmental Disability ☐ Division of Mental Health

☐ Illinois Department of Healthcare and Family Services

_____ _____ _____

Signature of Individual Certifying Results | Title | Date

_____ _____

Agency/Office | Phone Number

HFS 2536 (R-7-05)