



HELTON HOUSE INC.
REFERRAL SCREENING FORM
PHONE: (434)392-9276 FAX: (434)392-1509

Individuals Name: _____ **Medicaid Number:** _____

Services Requested

- ☐ Psycho-Social Rehab ☐ Mental Health ☐ Non-Center Based Services (CE)
☐ Group Day Services ☐ Residential Services

Please attach the individual's most recent psychiatric, psychological, and neurological exams

Waiver Information

- ☐ DD Waiver ☐ CCC Plus Waiver ☐ CL Waiver
☐ FIS Waiver ☐ BI Waiver ☐ EPSDT ☐ Other:

Waiver Slot Status: ☐ Active ☐ Pending ☐ Waiting List

Waiver Assigned Support Coordinator: _____

Support Coordination Agency/CSB & Phone Number: _____

DMAS/Medicaid Number: _____

Date Waiver Services Started (if applicable): _____

Current Waiver Services Received:

Level of Support Needed: ☐ Independent Support ☐ Intermittent Support

☐ Extensive Support ☐ Pervasive Support

Does the individual currently receive residential services? ☐ Yes ☐ No

If yes, provider name: _____

Has the individual previously received waiver services? ☐ Yes ☐ No

If yes, please explain:

Individuals Name: _____ **Medicaid Number:** _____

IDENTIFYING INFORMATION

Full Name: _____ Gender: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

Telephone Number (if applicable): _____

Marital Status: _____

Emergency Contact

Name: _____

Address: _____

Telephone Number: _____

Relationship to consumer: _____

Legal Guardian

Name: _____

Address: _____

Telephone Number: _____

Primary Care Physician or Regularly Used Medical Practice

Physician Name: _____

Agency: _____

Phone Number: _____

Psychiatrist/Nurse Practitioner

Name: _____

Agency: _____

Phone Number: _____

Other Medical Professional or Counselor

Name: _____

Agency: _____

Phone Number: _____

REFERRAL SOURCE INFORMATION

Name: _____

Address: _____

Telephone Number: _____

Relationship to consumer: _____

Please describe any family/friend relationships including family/friend phone number.

Individuals Name: _____ **Medicaid Number:** _____

Reason for Referral: (please include whether purpose is for further assessment, placement on a waiting list, or admission to the services)

Directions to the individual's residence:

PSYCHIATRIC HOSPITALIZATIONS

Number of psychiatric hospitalizations: _____

Most recent admission and discharge date in last 12 months:

Was this hospitalization Voluntary or Involuntary: _____

What were the precipitating factors?

CRIMINAL JUSTICE STATUS

Number of incarcerations: _____

Reason(s) for incarceration

Current Criminal Justice Status (if applicable): _____

Individuals Name: _____ **Medicaid Number:** _____

INDIVIDUAL HEALTH

Allergies: _____

Individuals mental/intellectual diagnosis:

Individuals' Health Disorder(s):

What is the onset/duration of the individual's medical, mental and/or behavioral problems?

Does the individual have an infectious disease? ☐ No ☐ Yes

Does the individual have a history of seizures, convulsions with high temperatures, fainting spells or staring spells? ☐ No ☐ Yes

Does the individual require a specialized diet? ☐ No ☐ Yes

Does the individual use tobacco/nicotine products? ☐ No ☐ Yes

What is the individual's substance use and abuse history? (including nicotine):

History of medical hospitalizations:

Serious illnesses and/or chronic conditions of parents and siblings:

Please check all that apply:

Orthopedic Devices:

() Wheelchair () Braces () Helmet () Walker () Toilet Chair

() Shower Chair () Other - _____

Speech:

() Speech Understandable () Sign Language () Non-Verbal

() Computer Communication Board () Other - _____

Physical Handicaps:

() Wears Glasses () Legally Blind () Tunnel Vision () Hearing Aid

() Hearing Loss () Other - _____

Individuals Name: _____ Medicaid Number: _____

Current Medications

Date Prescribed	Medication	Dose	Route	Schedule	Physician

INDIVIDUAL NEEDS

- ☐ Medication Management
- ☐ Contact/follow up with medical provider
- ☐ Health monitoring
- ☐ Recreation/leisure supports
- ☐ Personal hygiene
- ☐ Activities of daily living
- ☐ Communication skills
- ☐ Money management
- ☐ Interpersonal skills
- ☐ Conflict resolution
- ☐ Other: _____

BEHAVIOR ISSUES

Please describe any history of behaviors, aggression, elopement, self-harm, or risks:

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EDUCATIONAL AND VOCATIONAL HISTORY

What was the last grade the individual completed? _____

If the individual graduated, what type of diploma was received?

Did the individual have any issues (mental, behavioral, and medical) in school?

Please describe the individual's vocational history:

Residential Services Financial Information

SSI Monthly Amount: _____

SSA Monthly Amount: _____

SSDI Monthly Amount: _____

Other: _____

Medicare Number (if applicable): _____

Printed Name of Referral Source: _____

Signature of Referral Source: _____ Date: _____

Individuals Name: _____ **Medicaid Number:** _____

HELTON HOUSE USE ONLY

Status of individual:

☐ Accepted ☐ Waiting List ☐ Not Accepted

Rationale for Acceptance:

Program Director Signature: _____

Date: _____

Updated: May 2026