



OBRA-1 INITIAL SCREEN

Identification of Individuals for Whom There is a Reasonable Basis to Suspect a Developmental Disability or a Mental Illness

PART I. IDENTIFYING INFORMATION:

Last Name: _____ First Name: _____ MI: _____
Social Security: _____ Birth Date: ____ / ____ / ____

PART II. REASONABLE BASIS TO SUSPECT A DEVELOPMENTAL DISABILITY:

In order to determine whether there is a reasonable basis to suspect a developmental disability, the person conducting this screen must complete all of the items in Part II.

- The individual has been formally diagnosed with (Check applicable condition):
 Mental Retardation Related condition such as Cerebral Palsy Epilepsy Autism
 or any other condition (other than mental illness) found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with mental retardation and requires services similar to those required for such individuals **AND** the condition was manifested prior to the age of 22.
 ____ Yes ____ No
- The individual experienced seizures prior to the age of 22. ____ Yes ____ No
- The individual has received special education and/or day program services. ____ Yes ____ No
- The individual remained at home with family and did not go to school or work. ____ Yes ____ No
- There are other indicators of mental retardation or developmental disability. ____ Yes ____ No
Specify other indicator(s): _____

PART III. REASONABLE BASIS TO SUSPECT A MENTAL ILLNESS:

In order to determine whether there is a reasonable basis to suspect a mental illness, the person conducting this screen must complete all of the items in Part III.

- The individual has been formally diagnosed with a mental illness verified by a DSM-IV classification which substantially impairs the person’s cognitive, emotional and/or behavioral functioning, excluding organic disorders/dementia, developmental disabilities, and alcohol/substance abuse. ____ Yes ____ No
- The individual has a history of psychiatric hospitalization. ____ Yes ____ No
- The individual has a history of outpatient mental health services. ____ Yes ____ No
- There are other indicators of mental illness. ____ Yes ____ No
Specify other indicator(s): _____

Signature _____ Date _____
Organization Name _____ Phone # _____

Note: If any of the items in Part II or III is marked "yes", complete PART IV and refer to the appropriate DD PAS or MH PAS agent. Answering "yes" to any of the items does not automatically mean that the individual has a developmental disability or mental illness, only that the conditions may exist. If all items are marked no, the remaining parts of this form are not applicable. In that case, sign and date the form and proceed with the routine screen.



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PART IV. (To be completed by the initial screener only if a "yes" is marked in any item in Part II or III.) Based on the initial OBRA-1 review, the individual has been referred to one of the following authorized pre-admission screening entities. Indicate the date of referral. Indicate also the type and name of the organization to which the individual is being referred. **(Note:** If the determinations reflect both a developmental disability and mental illness, refer the individual to the DD PAS agent.)

Date of Referral to Organization: _____ / _____ / _____

(Check One): DD PAS MH PAS

Name of organization to which the individual is being referred: _____

PART V. (To be completed only by a DD or MH PAS agent if he or she determines there is not a developmental disability or mental illness in the case of this referral.)

Date of Referral to Organization Indicated Below: _____ / _____ / _____

1. Although an item was marked yes on the preceding page, the individual does not need a Level II assessment by this agency because:

2. The individual, therefore, is being referred as follows:

(Check One): DD PAS MH PAS ORS Department On Aging

Name of organization to which the individual is being referred: _____

Signature _____ Date _____

Agency _____ Phone _____

Note: An authorized agent must complete an OBRA-1 for all individuals who are seeking admission to a nursing facility or a DD Medicaid funded residential setting. An authorized agent must sign and date each applicable section of this form prior to an individual being admitted to a nursing facility. Signature by anyone other than an authorized agent of the State will be considered invalid. Payment for nursing facility services will not be made by the State of Illinois for individuals without an OBRA-1.