Intake Guide for Case Managers

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Purpose

An APD service intake gathers information from an individual or their representative. The details help identify care needs and the APD programs that may meet those needs. It provides eligibility information for APD programs. It also informs them of their right to apply for services. Everyone has the right to apply for benefits, regardless of their eligibility for a program, based on the information they provide.

This guide explains the basics and expectations of these conversations. Following this guide helps to ensure everyone has the same experience, no matter which office they go to. Follow this guide and the local office's business processes to complete an intake request.

Requesting APD Services

1. APD services include:
* Long-term services and supports (LTSS)
	+ In-home
	+ Residential
	+ PACE
	+ ICP
	+ Nursing facility
* State Plan Personal Care (SPPC)
* Oregon Project Independence – Medicaid (OPI-M)
* Oregon Project Independence (OPI)

An individual or a representative on behalf of the individual may contact a local office to ask questions or gather information about APD services. A request for information only is not considered a request for services.

It becomes an official request when the individual or their legal representative agrees to apply for APD services. The date of request (DOR) may differ if the services request is initiated by a third party and the individual has not consented to applying for APD services.

Sometimes, it may not be a direct request, and you must clarify what the individual or representative is saying. You might notice that the conversation has become a service request if:

There are unmet needs (i.e., needing help with getting around the house or toileting)

A history of hospitalizations

Concerns about health and safety

1. Who can initiate a service intake request?
* The individual
* Their representative. This may include:
	+ Spouse, significant other, or partner
	+ Legal representative (court-appointed guardian)
		- Power of Attorney (POA) does not meet the criteria of a legal representative
	+ Other family
	+ Friend(s)
* Community partners. For example, this may include:
	+ Coordinated Care Organizations (CCO)
	+ Mental or Behavioral health providers (see [an individual’s right to an assessment](#Right))
	+ Hospitals
	+ Doctor offices
	+ Centers for Independent Living (CIL)

An individual can appoint a representative to assist with the intake process. Please review the [Comparison of In-home Service Plan Assistance Types/Roles](http://www.dhs.state.or.us/spd/tools/cm/inhome/Comparison%20of%20In-Home%20Service%20Plan%20Assistance%20Roles%207-11-22.pdf) guide to understand roles. An Authorized Representative (form MSC 0231) is a role specific to financial eligibility.

1. Service intake requests for incapacitated individuals

When an individual has been deemed incapacitated and needs APD services to meet their care needs, someone acting responsibly may complete a service intake request for the incapacitated individual. This person must be age 18 or older.

“*Incapacitated” means a condition in which a person’s ability to receive and evaluate information effectively or to communicate decisions is impaired to such an extent that the person presently lacks the capacity to meet the essential requirements for the person’s physical health or safety. “Meeting the essential requirements for physical health and safety” means those actions necessary to provide the health care, food, shelter, clothing, personal hygiene, and other care without which serious physical injury or illness is likely to occur.* [ORS 125.005](https://oregon.public.law/statutes/ors_125.005)

The Department considers someone "acting responsibly" when we can determine with certainty that someone is acting in good faith and the individual’s best interest. Ideally, the person has enough knowledge of the individual’s circumstances to accurately complete the service intake request. However, there may be times when the person is an acquaintance, distant relative, or community partner. This person should be someone who advocates for the individual, including how and where they would prefer to have their care needs met.

A person acting responsible for an incapacitated individual may:

* Assist with completing the service intake
* Schedule the assessment
* Coordinate information
* Help identify needs and express the individual’s desired care setting if known.

This same person can assist with completing the financial eligibility process in ONE for new applicants only. See [QRG Who Can Apply](https://dhsoha.sharepoint.com/teams/Hub-DHS-ET/SitePages/QRGs.aspx).

**Important:**

* In Oregon, only the courts can determine capacity and appoint legal representation (i.e., Guardianship). Staff should always start with the assumption that the individual has capacity.
* Even with someone acting responsibly for an incapacitated individual, the individual can refuse APD services. Should they refuse, only a court-appointed guardian (legal representative) can supersede the individual's choice and apply for services.
* Civilly committed individuals may still refuse to apply/receive APD services. Should they refuse, only a court-appointed guardian can supersede the individual's choice and apply for APD services.
1. When someone other than the individual requests services

Others can ask about and initiate a request for APD services on someone's behalf. The individual or their legal representative must agree to apply. When this occurs, do the following:

* Gather information from the caller.
* Only share the information about an individual's existing Oregon ACCESS (OA) case with the caller if the individual has consented.
* Explain to the caller that the next steps will be contacting the individual and discussing APD services with them.
* Contact the individual or their legal representative to discuss APD services and inquire if they wish to proceed with the request (see [What to do when an individual does not respond to attempted contacts](#NoResponse)).
* Complete the service intake if the individual or legal representative agrees. The individual may ask you to talk to someone else to fulfill the service request.
* If the individual or their legal representative declines APD services, narrate the decision in OA. Add a case note to ONE. No SDS 540 is needed because the individual or their legal representative did not agree to continue with the request. This applies to a ONE case marked yes for LTC and the individual or their representative does not consent to an APD services intake.
	+ You need an SDS 540 form when someone agrees to an APD services request and later withdraws it. See the [Voluntary Withdraw](#VW) section of this document for SDS 540 language or visit [Decision Notice Preparation Tips](http://www.dhs.state.or.us/spd/tools/additional/workergd/Decision%20Notice%20Preparation%20Tips%204-25-23.pdf) on CM Tools.
* If someone calls the office asking about APD services for an individual who said no, you can listen to their concern but **only give out information if the individual permits** you. Additional guidance may include but is not limited to:
	+ Suggest the caller talk to the individual about their care needs and applying for services.
	+ Discuss with the individual alternative ways to meet their care needs with or without services.
	+ Offer local resources and contact information for ADRC.
1. Creating an intake record

You must document each service request in OA and include the DOR. Begin by searching OA for a record of the individual.

* Check ONE to see if there is a case, a DOR and, what kind of benefits a person is receiving, if any.
* If there is a case in ONE, use the IE/ME download button to pull data from ONE. If the information is incorrect in ONE, work with an eligibility worker to get the information updated.
* If a case and screening module exists in OA, update the screening module with the individual’s information and any changes.
* If a case exists but has no screening module, create a screening module record to document the request.
* If no case or screening module exists, do not create a screening module record until you have obtained and verified the following information:
	+ Full legal name
	+ Date of birth
	+ Social security number
		- This field is not required for individuals without a social security number. Examples include refugees and Healthier Oregon participants.
	+ A contact number for the individual (optional)
* Use ONE to verify an individual’s information or to find missing information. The **Individual Summary** screen displays all the information needed to create an OA screening module (see the ONE [LTC Service Request Task](https://dhsoha.sharepoint.com/teams/Hub-DHS-ET/SitePages/QRGs.aspx) QRG). Information from ONE can be downloaded to OA from the IE/ME screen in OA.

1. What to do when an individual does not respond to attempted contacts

When limited information is available, you should check ONE to see if the individual has an existing ONE case for additional details.

At least three attempts to contact the individual or their legal representative must be made and narrated in the OA screening module when the case can be created.

At times, we may only receive limited information, such as a callback number from someone calling on behalf of the individual or a voicemail. Other times, staff may have more details, including a mailing address.

You must:

* Attempt to reach the individual by phone on two separate days/times.
	+ Try contacting the individual in the morning and the afternoon on different days. Narrate all attempts.
* For a third attempt, send an [intake no-contact letter](https://dhsoha.sharepoint.com/%3Aw%3A/r/teams/Hub-ODHS-APD-Staff-Tools/_layouts/15/Doc.aspx?sourcedoc=%7BA6B77F97-AE5D-47FC-913F-E59B942357F7%7D&file=Intake%20No%20Contact%20Letter%203-15-24.docx&action=default&mobileredirect=true) when a mailing address is on file, on APD/AAA letterhead, and narrate the action. You must attempt a third call if no address is on file and narrate the attempt. After these attempts, you can stop contacting the individual for an intake request.

An individual’s right to an assessment

A service request is not an opportunity for staff to determine if an individual may or may not be eligible. It’s an opportunity to explain APD programs, eligibility criteria, and requirements clearly, provide the [Estate Administration Units (EAU)](https://www.oregon.gov/odhs/financial-recovery/pages/estate-recovery.aspx?utm_source=ODHS&utm_medium=egov_redirect&utm_campaign=https%3A%2F%2Fwww.oregon.gov%2Fdhs%2Fbusiness-services%2Fopar%2Fpages%2Festate-admin.aspx) contact information, and inform the individual of their right to request an assessment to determine their eligibility accurately. Document the individual's decision in OA.

* Under no circumstances may you “screen” an individual out or deter them from applying for APD services.
* You should still complete an assessment if the individual is applying for or already has other services, such as I/DD or MH/BH.
* You should still complete an assessment if the individual needs a MED review. Do not postpone the assessment while awaiting records. The individual needs to have their SPL determined first.

DOR and 45-day expectations

The DOR is the day an individual or their legal representative initiates a service intake request. ([OAR 461-115-0030](https://sharedsystems.dhsoha.state.or.us/caf/arm/A/461-115-0030.htm))

* Note: The DOR is the day someone acting responsibly for an incapacitated adult initiates the request only if the individual agrees. If the individual does not want to pursue APD services, only a court-appointed guardian can supersede the individual’s choice.

Often, this occurs in the ONE system when a financial eligibility worker (EW) indicates the individual is requesting APD services in the financial review process. Other times, this may occur outside the ONE system.

No matter the initial point of contact, staff must document the DOR in OA and ONE and work to complete the service intake process and eligibility determination within 45 days. ([OAR 461-115-0190](https://sharedsystems.dhsoha.state.or.us/caf/arm/A/461-115-0190.htm))

For assistance with service and medical effective date determinations, see this guide's [Effective Dates for APD Services](#ED) section.

**Important:** Service eligibility and financial eligibility must be completed within 45 days of the DOR. Do not wait for the financial review to complete a service eligibility determination or vice versa – complete them simultaneously.

Preparing for an intake conversation

Sometimes, we may have information about the individual before speaking to them. This knowledge can improve communication with the individual and make for a smoother conversation. When possible, prepare for a discussion by following these best practices:

* Check whether a case or an intake (known as screening) in OA already exists.
* Check if the case or intake is in another branch.
* Review ONE or MMIS to see if the individual has open medical, has started the application process, has any pending requests for information (RFIs), or needs to connect with an EW to apply.
* Has the intake process started?
* Review recent narrations.
* Have there been multiple community referrals (MH/BH, CCO, Hospitals, CILs, APS)
	+ If so, why?
* Were they previously assessed? If yes, what was their SPL and previously reported needs?
	+ Prepare to discuss if any previously reported care needs have changed.

The time it takes to complete an intake

* The time it takes to complete a services intake varies. Often, in-person requests can take longer to complete than a phone request.
* There is no time limit expectation for staff to complete a services intake. However, be mindful of the volume of requests and if other individuals are waiting.
* Be compassionate and allow the individual or representative time to speak to each question asked.
	+ Sometimes, you need to direct the conversation to the next question or topic.
	+ Workday Learning offers resources to help with interviewing:
		- [ODHS – SSTU – Motivational Interviewing](https://wd5.myworkday.com/oregon/email-universal/inst/17816%24239/rel-task/2998%2429489.htmld)
		- [ODHS – SSTU – Ask, Ask, Offer, Ask](https://wd5.myworkday.com/oregon/email-universal/inst/17816%2499/rel-task/2998%2429489.htmld)
* Remember, a service intake is not an assessment. It's an opportunity to gather and share information about APD programs and connect the individual with community resources.

What does a service intake conversation look like?

There is no prescribed order for an intake conversation. Discussions should be natural and conversational. Topics to discuss include:

* The primary reason for requesting services?
* Services the individual is already receiving, such as:
	+ I/DD services
	+ Behavioral/Mental health
	+ Veteran benefits

**Important:** Individuals may be eligible to receive services from behavioral and mental health programs while receiving APD services. Services can include outpatient and some case management. Don't deter someone from applying for APD services by saying they'll lose services from another program. Review for duplication of services can occur **after** the individual has been determined eligible for APD services.

* Have they ever received LTSS, SPPC, or OPI benefits?
* Discuss and summarize the individuals reported care needs.
	+ Are there any critical care needs going unmet?
	+ It is not necessary to discuss duration and frequency of needs. This will be captured in their assessment.
* Are they pending a hospital or skilled NF discharge?
* Is there an APS related concern?
* Are there any safety concerns for the individual? In the home?
* If they are reporting needs for IADLs, don't assume they are not eligible. Ask why they need the assistance. For example, someone who indicates they only need help with housekeeping. Assistance with housekeeping may show an unmet ADL, such as poor mobility and range of motion.
	+ Completing an assessment for an individual when they request it ensures that we address all their needs.

**Important:** These questions and any discussion about care needs are meant to be a high-level overview to allow you to gather information and discuss which APD program may be best suited for the individual. The intake is not an assessment, nor should the details gathered be used to discourage an individual from applying for APD services.

* Things to consider when speaking with an individual that may indicate additional steps the individual and CM will need to take:
	+ Are there indicators of mental/behavioral health needs, a history of treatment, or substance use disorder? If under 65 (60 for OPI-M), a MED referral may be required. Is a release of information (ROI) form needed?
	+ Has ONE indicated that the case will require a PMDDT review? Will assistance with gathering additional records be needed?
		- Individuals applying for OPI-M may need a PMDDT review and will occur outside of ONE. Individuals with MAGI may require a PMDDT review if they do not have a disability determination and are interested in OPI-M.
	+ Does the consumer need to go to an NF? Will a PAS/PASRR be required? Should a Diversion/Transition coordinator be added to the case?
* Where is the individual currently residing? What is their desired care setting?
* Does the individual have any natural support or community involvement?
* Does the individual have someone identified to provide care if eligible? If a friend or family member is going to be HCW, do they have a provider number? If not, refer them to the HCW coordinator to begin the HCW application process.
* Provide a general overview of liability and room & board for CBC settings. See [Financial: Scope of CM Responsibility](#Scope) for more details.

ONE financial review status

Review the individual’s financial eligibility (FE) status in ONE.

* If FE has not begun, discuss with the individual the need to schedule an appointment. Follow your local process for communicating information to an EW or conduct a warm hand-off to an EW within your office or schedule the appointment in ONE for the individual.).
* Add a case note in ONE about the status of the service request for an EW.
* Connect with your supervisor to update ONE rights if needed.

Financial: Scope of CM responsibility

CMs are responsible for encouraging communication between an individual and EWs when necessary. They are not responsible for completing the FE review. CMs are responsible for informing EW and APS of information they learn while working with the individual. CMs should assist with supporting EWs in the following areas:

* Income Cap Trusts (ICT) - convey the importance of completing the ICT and assist EW with conducting the review by following up with the individual as needed.
	+ Explain to the individual that they must establish an ICT before LTSS benefits can be approved. CMs can provide blank ICTs to the individual or their representative.
	+ The CA/PS must be completed to ensure the individual meets SPL.
	+ Only advise the individual to create an ICT once they are SPL eligible. Once the individual sets up the ICT account, you can approve the benefit plan through OA.
	+ The effective date for an ICT is the first of the month in which it is signed and cannot be approved retroactively. It is important the individual or their representative understands the person will not be eligible until the ICT is completed.
* Communicate information about potential service liabilities for CBC or NF settings. Explain to the individual their responsibility to pay the service liability and the impact non-payment may have on their services. Narrate these conversations.
* The medical notice of eligibility (NOE) does not address room and board (R&B) or Cost of Care cases. CMs can support EWs by discussing the individual R&B responsibility and the difference between R&B and service liability. Narrate these conversations.
* For a disqualifying (DQ) period to be authorized, the individual must meet *all other* eligibility criteria except for the disqualifying transfer. Without the DQ transfer, we would be able to open services. The individual must be SPL eligible before the DQ period can be authorized. CM’s must communicate the individuals service eligibility determination (eligible or ineligible) to an EW. Do not authorize a service plan when an individual has a DQ. Doing so will allow the ONE system to approve the case without the individual serving the DQ.
* Add a case note in ONE when the individual has been assessed and meets the level of care requirements for services and communicate eligibility with a local EW. Case notes must also be added if an eligibility decision will exceed 45 days from the DOR. This allows an EW to update ONE and prevent the system from generating an auto-denial.

**Important:** Do not ask about financial information collected during an individual's financial eligibility review. It is duplicative work and unnecessarily burdens the individual to repeat information. Duplicative information includes:

* Income and resources
* Transfer of assets
* Marital status

**Exception:** You may ask minimal financial questions if the intake worker is scheduling an appointment in ONE. If the answer is yes to any of the following questions, the individual will need a complex LTC appointment.

1. Is the person who needs long term services and supports married?
2. Does the person who is requesting long term services and supports have a total monthly income of $2382.00 or more?
3. Has the person that is requesting long term services and supports transferred/sold/traded any assets in the last 5 years?
4. Does the person who is requesting long term services and supports have a trust and/or annuity?

Any information volunteered by the individual can be captured and needs to be relayed to an EW.

**Note for individuals applying for OPI**: Information about income and resources may be needed. OPI individuals do not go through ONE; discussing this information is not duplicative work.

Scheduling an assessment

* Assessments should be scheduled in the individual’s home or care setting as soon as possible with best practice of no more than 14 calendar days from the DOR whenever possible to ensure you meet the 45-day requirement.
* Local office workloads may impact the timeframes for scheduling. However, you must send a decision notice by the 45th day of the DOR.
	+ ONE will deny benefits if an eligibility determination is not completed within 45 days unless actions are taken in ONE to extend the SELG due date.
* Individuals can invite anyone they want to the assessment to participate.

Effective Dates for APD Services

An individual may ask about when their services will begin. You need to become familiar with the effective dates rule [OAR 461-180-0040](https://sharedsystems.dhsoha.state.or.us/caf/arm/B/461-180-0040.htm). Effective dates for individuals requesting services in their home, CBC facility, or NF will vary.

Best practices:

* Inform the individual of the 45-day requirement for eligibility determinations and delays in providing information that can extend this period.
	+ Timely responses to ROIs and RFIs in ONE help with eligibility determination.
* Communicate to the individual that they must complete the financial and service eligibility reviews before services can be approved. Eligibility includes waiting on the results of a MED review.
* Explain that in-home providers can only begin working with prior authorization from the Department. This excludes ICP providers. Please review [ICP materials](https://dhsoha.sharepoint.com/teams/Hub-ODHS-APD-Staff-Tools/SitePages/In-Home-Programs-Services.aspx#independent-choices-program-%28icp%29) for more details.

Voluntary withdrawal from service intake request

A Voluntary Agreement to Take Action form MSC 457D is not required for an individual to withdraw a new request for APD services. When a CM receives an oral request from an individual or their representative to cancel the request for services, the CM should take these actions:

* When the verbal request is received, narrate the date in OA.
* Create and send an SDS 540 **basic decision notice** with the following language:
	+ The Department received your oral request to voluntarily withdraw your application. This notice confirms your requested action. OAR 461-175-0340, 461-175-0200(8), 461-115-0010(6), 461-115-0010(7) and 410-120-0006.
* CM must add notice to EDMS and may close out the service case according to local office procedure.
* CM must add a note to the individuals ONE case and follow your local process for notifying an EW of the change. This allows an EW to take appropriate actions when the individual is no longer applying for APD services.

See [APD-PT-23-006](http://www.dhs.state.or.us/policy/spd/transmit/pt/2023/pt23006.pdf) for more details on Voluntary Action for Long-Term Services and Supports.

**Important:** Should the individual or their representative contact the office or CM within 45 days from the initial DOR for APD services, their request should be reinstated as an existing request. It should be treated as a new request if it is more than 45 days from the DOR.

A withdrawal from services does not impact an individual’s other benefits. Individuals will need to complete a separate withdraw request for benefits authorized in the ONE system.

Misc.

* Waivered Case Management Services (WCM): Direct and indirect contacts are not a part of the intake process. They only count from the effective date of APD services eligibility onward.

Acronym Table

**APD**; “Aging and People with Disabilities." Refers to the program within the Oregon Department of Human Services (ODHS) primarily responsible for serving the aged and people with disabilities.

**AAA**; “Area Agency on Aging." This means the Department designated agency is responsible for providing a comprehensive and coordinated system of services to individuals in a planning and service area. The term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300

**CBC**; “Community-Based Care”. This means a residential care setting such as an assisted living facility (ALF), residential care facility (RCF), adult foster home (AFH), or specialized living facility (SLF).

**CM**; “Case Manager”. This means an employee of the Department or AAA who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The CM authorizes and implements the service plan and monitors the services delivered.

**CCO**; “Coordinated Care Organization”. This means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.572 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.

**DOR**; “Date of Request”. For all programs covered by Oregon Administrative Rule (OAR) chapter 461, an individual or someone authorized to act on behalf of an individual must contact the Department or use another appropriate method to request benefits. The request may be oral or in writing. See [OAR 461-115-0150](https://sharedsystems.dhsoha.state.or.us/caf/arm/A/461-115-0150.htm) for other ways an individual may apply.

**HCW**; “Homecare Worker”. This means a provider with an APD-approved background check and provider number directly employed by an eligible individual to provide hourly services according to their service plan.

**ICP**; “Independent Choices Program”. This means a self-directed in-home services program in which a participant receives a cash benefit to purchase goods and services identified in the participant's service plan and prior approved by the Department or Area Agency on Aging

**LTSS**; "Long-Term Services and Supports." This means all Medicaid-funded through CMS approved 1915(c) and 1915(k) waivers, including both:

* “Long-term Care,” the system through which ODHS provides a broad range of social and health services to eligible adults aged, blind, or have disabilities for extended periods.
* “Home and Community-Based Services,” the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization.

**MED**; “Mental or Emotional Disorder ." This means a schizophrenic, mood, paranoid, panic, or other anxiety disorder. A somatoform, personality, dissociative, factitious, eating, sleeping, impulse control, or adjustment disorder. Or other psychotic disorders as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual.

**NF**; “Nursing Facility”. This means an establishment licensed and certified by ODHS as an NF. An NF also means a Medicaid-certified NF only if identified as such.

**OPI**; "Oregon Project Independence". It is a state-funded program promoting quality of life and independent living among older adults and people with physical disabilities utilizing preventative and long-term care services.

**OPI-M**; "Oregon Project Independence – Medicaid." It is an expansion program of the state-funded OPI program under a CMS-approved demonstration waiver.

**PACE**; “Program of All-Inclusive Care for the Elderly." It is a managed care entity that provides medical, dental, mental health, social services, transportation, and long-term care services to persons aged 55 and older on a prepaid capitated basis by a signed agreement with ODHS and CMS.

**SPL**; “Service Priority Level”. This means the order in which the Department and AAA staff identify individuals eligible for a nursing facility level of care, OPI, or home and community-based services. A lower SPL number indicates more significant or more severe functional impairment. The number is synonymous with the SPL.

**SPPC**; "State Plan Personal Care." This means the assistance with personal care, ADLs, and IADLs described in OAR [411-034-0020](https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SPPD/APDRules/411-034.pdf) is provided to an individual by a homecare worker or In-Home Care Agency.

Narration template

Staff should ONLY copy and paste TEXT from the template and NOT paste images or the document itself into Oregon ACCESS (OA) narration, as it will cause OA narration to malfunction.

\*\*New Service Intake Request\*\*

DOR: Click to enter a date.

SELG record required by date: Click to enter a date.

Consumers name/phone number: Click to enter text.

Caller name (if different): Click to enter text. #: Click to enter text.

 Relationship: Click to enter text.

Who is the primary contact: Choose an item.

Representative: Choose

Name: Click to enter text. #: Click to enter text.

Marital status: Choose

If married, is the spouse requesting or receiving services: Choose

Guardian/Conservator/POA: Choose

Name: Click to enter text. #: Click to enter text.

Summary of potential needs/concerns: Click to enter text.

Possible MED needed (if under 65): Choose

DT/TC referral needed: Choose

Financial Eligibility status: Choose

EAU discussed: Choose

R&B/Liability discussed: Choose

Assigned CM (name added to the case): Click to enter text.

Assessment scheduled: Choose an item.

Date: Click to enter a date. Time: Click to enter time.

Location: Choose.

Address/RM# (if not the individual’s home): Click to enter text.

Case note added to ONE with assessment date: Choose