**DHHS Children’s Assessment Clinic Pre-Screening Form**

**Please check location:** [ ]  **Murdoch** [ ]  **Riddle**

**Date:** Click here to enter a date.

**Child’s FIRST Name:** Click here to enter text. **Child’s Birthdate:** Click here to enter text.

**Responsible MCO:** Choose an item. **Person completing form:** Click here to enter text.

**MCO Contact phone number:** Click here to enter text. **MCO Contact e-mail:** Click here to enter text.

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| **Basic Eligibility Questions:** |
| **Is the child Medicaid eligible?** Choose an item.**Does the child have an ID diagnosis?** Choose an item. **If yes, level of ID?** Choose an item.**Does the child have an ASD diagnosis?** Choose an item.**Does the child have a Mental Health diagnosis?** Choose an item. **If yes, please list:** Click here to enter text.**Is the child at risk of not being able to enter, return to, or maintain community placement because of behaviors toward themselves, others, and/or property?** Choose an item. |

**Reason child would be referred to the Assessment Clinic:** Click here to enter text.

*Please e-mail the completed form to Murdoch at* *MDCAssessment.Clinic@dhhs.nc.gov* *or to Riddle at* *JIRAssessment. Clinic@dhhs.nc.gov**. You can expect a response within 3 business days.*