****New Jersey Department of Human Services

Division of Developmental Disabilities

www.nj.gov/humanservices/ddd

**DDD Mental Health Pre-Screening Checklist**

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| --- | --- |
| **Name:** | **Date:** |
| **DDD#:** | **Support Coordination Agency:** |
| **These questions are to be used to guide discussion with the individual, family, and his/her caregivers about any possible indicators that a mental health evaluation may be necessary. A “yes” response to any of these questions may be an indicator that someone might be experiencing a mental health problem and a further assessment and/or referral to mental health services may be required.** |
| **Questions** |
| **Behavioral/Mental Health Changes** | **Yes** | **No** |
| 1. Has there been a change in the way that the person reacts/interacts with caregivers?
 |  |  |
| 1. Does the person hurt him/herself or others?
 |  |  |
| 2a. If yes, is this behavior new? |  |  |
| 1. Has the person been sleeping more or less than usual?
 |  |  |
| 1. Has there been a significant change in the person’s level of activity?
 |  |  |
| 1. Is the person overly fearful?
 |  |  |
| 5a. If yes, is this behavior new? |  |  |
| 1. Does the person seem sadder or appear to be more socially withdrawn than they have in the past?
 |  |  |
| 1. Is the person extremely confused or disoriented?
 |  |  |
| 7a. If yes, is this behavior new? |  |  |
| 1. Does the person hear voices even when no one is there? (This is not the same thing as talking to oneself for company or to reduce anxiety.)
 |  |  |
| 8a. If yes, is this behavior new? |  |  |
| 1. Does the person have a current or past psychiatric or mental health diagnosis?
 |  |  |
|  9a. Does the person currently take medication for mental health or behavioral  issue(s)? |  |  |
| 9b.Is the person currently under treatment with a psychiatrist, APN, primary care physician or another type of mental health therapist? |  |  |
| 1. Is there a current behavior plan in place?
 |  |  |
| 1. Has the person ever attempted to commit suicide?

\*If yes, a safety plan is required to be outlined in the ISP |  |  |
| 1. Has the person verbalized a desire to commit suicide?

 \*Please note, a “yes” will require a direct referral to CARES (**888)393-3007**. |  |  |
| **Behavioral/Mental Health Changes Follow up** |
| Are any of these changes/behaviors interfering with the person’s day to day functioning? |  |  |
| Regarding the above questions, mark the box that indicates the type of follow up necessary: |
|[ ]  Currently being managed with no additional follow-up needed |
|[ ]  Referral to CARES and/or reach out to HMO Care Manager to refer to mental health services |
|[ ]  Revise ISP to address newly identified supports and service needs |
| **Please describe the necessary follow up:** |
| **Physical/Medical Changes** | **Yes** | **No** |
| 1. Has there been a change in the person’s appetite?
 |  |  |
| 1. Has the person gained or lost weight recently?
 |  |  |
| 1. Was the last medical evaluation more than a year ago?
 |  |  |
| 1. Have there been any recent medication changes?
 |  |  |
| 1. Is the person addressing his/her own health and wellbeing needs?
 |  |  |
| 1. Has the person recently been hospitalized for a severe medical condition?
 |  |  |
| **Physical/Medical Changes Follow up** |
| Are any of these changes interfering with the person’s day to day functioning? |  |  |
| Regarding the above questions, mark the box that indicates the type of follow up necessary: |
|[ ]  Currently being managed with no additional follow-up needed |
|[ ]  Referral to CARES, Medical Doctor, and/or reach out to HMO Care Manager to refer to appropriate mental health/ appropriate services needed |
|[ ]  Revise ISP to address newly identified supports and service needs |
| **Please describe the necessary follow up:** |
| **Life Circumstance Changes** | **Yes** | **No** |
| 1. Has there been any recent change to the person’s environment or life circumstances that appear to be stressful or uncomfortable to them? (Examples: new roommate, death of someone close to them, new staff, etc…)
 |  |  |
| 1. Has the person experienced any traumatic events recently (examples: a car accident, loss of a loved one or caregiver, victim of a crime)?
 |  |  |
| **Life Circumstance Changes Follow up** |
| Are any of these changes interfering with the person’s day to day functioning? |
| Regarding the above questions, mark the box that indicates the type of follow up necessary: |
|[ ]  Currently being managed with no additional follow-up needed |
|[ ]  Referral to CARES and/or reach out to HMO Care Manager to refer to keep services |
|[ ]  Revise ISP to address newly identified supports and service needs |
| Please describe the necessary follow up: |

*Questions in this Screen were adapted from Juanita St. Croix, Southern Network of Specialized Care, London, Ontario.*

**Additional Comments:**

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|  |  |
| Support Coordinator (Print) | Signature Date |
|  |  |
| Support Coordinator Supervisor (Print) | Signature Date |