**Sanilac County Community Mental Health Services**

**Summary of OBRA Screening**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_ TYPE: DD\_\_\_ Initial ARR\_\_\_\_

 MI\_\_\_ ARR\_\_\_\_

CASE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PAS\_\_\_\_

 Change in Condition\_\_\_\_

 Re- Eval \_\_\_\_

 HED\_\_\_\_

 Determination Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sent in Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE** | **ASSESSMENT** | **STAFF** | **TIME** | **COST** |
|  | OBRA Coord. |  |  |  |
|  | Psychosocial |  |  |  |
|  | Nursing |  |  |  |
|  | Psychiatric |  |  |  |
|  | Psychological |  |  |  |
|  | OT/PT |  |  |  |
|  |  |  |  |  |
|  |  | **TOTAL** |  |  |

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 OBRA Coordinator Date

FORWARD TO Accountant

BILL TO DCH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ESTABLISHED RATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RECEIVED FROM DCH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ AMOUNT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIRECTIONS:

The information on this form will be used to establish a charge for the completion of this assessment. It is therefore important that all assessments be entered (including psychiatric assessments) on this form upon completion of the OBRA review. Submit summary to the Accountant.