

# CASE MANAGEMENT SCREENING CRITERIA

Name of Person Referred: \_\_\_\_\_

Please check all that apply: **MUST MEET FOUR OF THESE:**

\_\_\_\_\_ **Low income, defined as no more than 150% of the poverty level (\$1,516 for individual, \$2,057 for couple)**

\_\_\_\_\_ **Impairments of two or more activities of daily living: (walking, dressing, bathing, eating, grooming, toileting)**

\_\_\_\_\_ **Inpatient hospitalization, stay at rehabilitation facility, or skilled nursing facility within the last two weeks**

\_\_\_\_\_ **Alzheimer's disease**

\_\_\_\_\_ **No caregiver support**

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\_\_\_\_\_ **REFERRAL TO BE ASSIGNED TO CARE COORDINATOR**

\_\_\_\_\_ **REFERRAL TO BE DECLINED**