New Jersey Department of Human Services
Division of Developmental Disabilities
www.nj.gov/humanservices/ddd

DDD Mental Health Pre-Screening Checklist

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?		
2. Does the person hurt him/herself or others?		
2a. If yes, is this behavior new?		
3. Has the person been sleeping more or less than usual?		
4. Has there been a significant change in the person's level of activity?		
5. Is the person overly fearful?		
5a. If yes, is this behavior new?		
6. Does the person seem sadder or appear to be more socially withdrawn than they have in the past?		
7. Is the person extremely confused or disoriented?		
7a. If yes, is this behavior new?		
8. 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?		
9. 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?		
10. Is there a current behavior plan in place?		
11. Has the person ever attempted to commit suicide? *If yes, a safety plan is required to be outlined in the ISP		
12. 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
13. Has there been a change in the person's appetite?		
14. Has the person gained or lost weight recently?		
15. Was the last medical evaluation more than a year ago?		
16. Have there been any recent medication changes?		
17. Is the person addressing his/her own health and wellbeing needs?		
18. 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
19. 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…)		
20. 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:

Support Coordinator (Print) Signature Date

Support Coordinator Supervisor (Print) Signature Date