Utah Department of
Health & Human Services
Services for People with Disabilities

REQUEST FOR ICD-10 CODE

Form 18

Version Date: March 2021

Instructions

The Division of Services for People with Disabilities (DSPD) requests confirmation of an ICD-10 diagnostic code for the applicant identified below in order to determine whether they meet service eligibility requirements. Form must be completed and signed by a licensed psychologist, medical doctor, or osteopathic doctor. Please return this form within 10 days to start the eligibility process. If you need help completing this form, please contact DSPD at 1-844-275-3773, Monday through Friday from 8 am to 5 pm.

SEND COMPLETED FORM BY EMAIL, MAIL, OR FAX.

Email: dspdintake@utah.gov

Mail: Division of Services for People with Disabilities Intake Unit 475 W. Price River Dr. #262 Price, UT 84501

Fax: 801-538-4279

Applicant Information

Name: ______________________ DOB: __________

Physician Information

Name: ______________________ Phone Number: ______________

Credentials: Licensed Psychologist ☐ MD ☐ DO ☐

Address: ____

PHYSICIAN CERTIFICATION

It is my conclusion that the Applicant meets the following primary ICD-10 Code and Diagnosis:

ICD-10 Code: __________ Diagnosis: ______________________________

If additional ICD-10 CM Codes and diagnoses apply, please list below:

ICD-10 Code: __________ Diagnosis: ______________________________

ICD-10 Code: __________ Diagnosis: ______________________________

ICD-10 Code: __________ Diagnosis: ______________________________

Signature: ______________________________ Date: __________

INTAKE SOCIAL HISTORY

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Date: ______________ Completed by: ______________________________

Applicant's Personal Information

Legal Name (First, Middle, Last): __________________________________ Preferred Name: ______________________________

Date of Birth: _______________ Primary Language: ______________________________

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

DSPD asks for the following information in order to help our staff use the most respectful language when talking to you. We want to understand who you are. Please help us serve you better by selecting each item that describes you. Thank you.

Race and Ethnicity:
☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian
☐ Hawaiian Native or Other Pacific Islander ☐ Hispanic, Latino/a/x, or Spanish Origin ☐ Multi-Race
☐ Middle Eastern or North African ☐ Non-Hispanic, Latino/a/x, or Spanish Origin ☐ White
☐ Prefer not to say Prefer to self-describe ______________________________

Gender Identity:
☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Cisgender
☐ Prefer not to say Prefer to self-describe ______________________________

Sexual Orientation:
☐ Heterosexual ☐ Gay or Lesbian ☐ Bisexual ☐ Queer ☐ Asexual
☐ Prefer not to say Prefer to self-describe ______________________________

Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them Other ____________

Guardianship Status: ☐ Own Guardian ☐ Biological Parent ☐ Adoptive Parent ☐ Youth in Care ☐ Guardian

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership ☐ Widowed

Applicant's Contact Information

Physical Address: ____________________ City: ______________ UT Zip Code: ________

Mailing Address: ____________________ City: ______________ UT Zip Code: ________

Phone Number: ______________ Email: ______________________________

Is the Applicant the primary contact for information? ○ Yes ○ No

IMPORTANT PEOPLE TO CONTACT

Please list no more than 3 people to act as primary and emergency contacts. Include parents and legal guardians if applicable, and at least one person who does not live with the Applicant. Legal guardians must provide a copy of their guardianship papers.

Contact One

Lives with Applicant? ○ Yes ○ No ☐ Primary contact

Name: ____________________ Pronoun: ____________ Relationship to Applicant: ______________

Address: ____________________ City: ______________ State: ______ Zip Code: ________

Phone Number: ____________ Email: ____________________ Primary Language: ______________

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

Contact Two

Lives with Applicant? ◯ Yes ◯ No ☐ Primary contact

Name: ____________ Pronoun: ____________ Relationship to Applicant: ____________

Address: ____________ City: ____________ State: ____________ Zip Code: ____________

Phone Number: ____________ Email: ____________ Primary Language: ____________

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

Contact Three

Lives with Applicant? ◯ Yes ◯ No ☐ Primary contact

Name: ____________ Pronoun: ____________ Relationship to Applicant: ____________

Address: ____________ City: ____________ State: ____________ Zip Code: ____________

Phone Number: ____________ Email: ____________ Primary Language: ____________

Communication Assistance: ☐ None required ☐ Spoken Language ☐ Signed Language ☐ AAC ☐ TTY

Applicant's Education History

Please list the current or last school attended.

Name of School: ____________ Type of School: ____________

School Contact Information: ____________

Does/did the Applicant receive early intervention services? ◯ Yes ◯ No

Does/did the Applicant receive special education services? ◯ Yes ◯ No

If still in school, what date will the Applicant graduate or transition out? ____________

Applicant's Employment History

For Applicants aged 16 years and older, please list their most recent job.

Employer: ______________________ ◯ Part-time ◯ Full-time

Start Date: __________ End Date: __________ Hours per week: __________ Hourly Wage: __________

Job Title/Description: ______________________

Type of Employment (please check one):

- ◯ Integrated Individual Employment (e.g. Applicant has/had own job in the community)
- ◯ Integrated Work Crew (e.g. Applicant works/worked in the community on a work crew)
- ◯ Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.)

Work Related Issues (i.e. any difficulties that affected job performance):

____

Work Related Successes, Special Skills, etc.:

____

Previously received Supported Employment through Vocational Rehabilitation? ◯ Yes ◯ No

If yes, what year did the Applicant receive employment services? __________

Is the Applicant seeking employment that requires ongoing support? ◯ Yes ◯ No

Does the Applicant currently have an open case with Vocational Rehabilitation? ◯ Yes ◯ No

If yes, which office: ______________ Office phone number: ______________

Areas of Concern

List any major health (physical, psychological, substance abuse, etc.) concerns, and the related diagnoses that affect the Applicant's life.

BEHAVIORAL HEALTH

Receiving support? ◯ Yes ◯ No

Need Support? ◯ Yes ◯ No

If Need Support, please describe.

MENTAL HEALTH

Receiving support? ◯ Yes ◯ No

Need Support? ◯ Yes ◯ No

If Need Support, please describe.

PHYSICAL HEALTH

Receiving support? ◯ Yes ◯ No

Need Support? ◯ Yes ◯ No

If Need Support, please describe.

SUBSTANCE MISUSE

Receiving support? ◯ Yes ◯ No

Need Support? ◯ Yes ◯ No

If Need Support, please describe.

SAFETY

Receiving support? ◯ Yes ◯ No

Need Support? ◯ Yes ◯ No

If Need Support, please describe.

OTHER

Receiving support? ◯ Yes ◯ No

Need Support? ◯ Yes ◯ No

If Need Support, please describe.

Brain Injury

Does the Applicant have a brain injury? ◯ Yes ◯ No

Did the brain injury occur pre or post birth? ◯ Pre ◯ Post

Date the brain injury occurred: ______________

Describe the cause of the brain injury.

Applicant's Medical/Specialized Equipment

Does the Applicant use any specialized equipment (e.g. wheel chair, walker, g-tube, ventilator, etc.)? ◯ Yes ◯ No

If Yes, please describe the specialized equipment used.

Applicant's Recent Hospitalizations

List any hospitalizations within the last year, including psychiatric care and in-patient residential treatment.

Facility Name ______________________

Reason for Admission ______________________

Admission Date ____________ Discharge Date ____________

Facility Name ______________________

Reason for Admission ______________________

Admission Date ____________ Discharge Date ____________

Nursing Facility or Intermediate Care Facility (ICF)

Is the Applicant now, or have they ever been a resident of a Nursing Facility? ◯ Yes ◯ No

Facility Name ______________________ Admission Date ____________ Discharge Date ____________