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

Intake checklist: acquired brain injury

Version Date: July, 2026

PRIVACY NOTICE: The information you provide on this form will be used to determine eligibility for division services. It will be used only by DHHS, if needed, or by a person or party contracted with DHHS. Without this information, we cannot make a determination about your eligibility. This data is part of record series 15376.

Intake steps

1. Send DSPD Intake all applicable eligibilty documents.
2. Intake specialist reviews your documents.
3. Intake specialist contacts you to schedule an appointment to complete the Needs Assessment Questionnaire (NAQ) and the comprehensive Brain Injury Assessment (CBIA).

Contact the Help Desk at 1-844-275-3773 for questions and help filling out intake forms.

Eligbility documents

Required for everyone

- [ ] Form 1-1: Request for Determination of Eligibility for Services
- [ ] Copy of Social Security Card
- [ ] Copy of birth certificate
- [ ] Social history
- [ ] Medical records (relevant documentation of the diagnosis)
- [ ] Form 18: Request for ICD code (completed by a medical professional whose scope of licensure includes the ability to render diagnoses.)

May be needed to determine your eligibility

- [ ] Copy of Medicaid Card (if not applicable, note in the social history.)
- [ ] Form 1-2: Authorization to Furnish Information and Release from Liability
- [ ] Guardianship papers (if a guardian is appointed by the court)

Send documents by email, mail, or fax

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

Email: dspdintake@utah.gov

Fax: 801-538-4279

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

Request for determination of eligibility for services

Form 1-1 Version Date: July, 2026

PRIVACY NOTICE: The information you provide on this form will be used to determine eligibility for division services. It will be used only by DHHS, if needed, or by a person or party contracted with DHHS. Without this information, we cannot make a determination about your eligibility. This data is part of record series 15376.

Instructions

Complete and return this form to start the eligibility process. This form requires a signature. It can be filled out and signed electronically. Return completed forms by email or mail. If you print the form, it must be scanned before returning by email.

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

Fax: 801-538-4279

Email: dspdintake@utah.gov

Applicant information

Legal name (first, middle, last):

Phone number: Email:

Date of birth: Legal sex:

Social security number: County:

Address (include zip code):

Contact person

Same as applicant ☐

Name: Phone number: Relationship:

Signature

I, the applicant, understand that by signing and returning this form that I am officially requesting the Utah Division of Services for People with Disabilities (DSPD) determine my eligibility for services. To determine eligibility, DSPD will collect and review medical and psychological information about me.

Signature: Date:

Signer is the: Applicant ☐ Parent ☐ Legal guardian ☐

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

Intake social history

Form 824-I
Version Date: July, 2026

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Date: Completed by:

Applicant's personal information

Legal name (first, middle, last): Preferred name:

Date of birth: Sex: Primary language:

Communication/translation Need: ☐ None required ☐ Spoken language ☐ Signed language ☐ AA ☐ TTY

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

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: Relationship to Applicant:

Address: City: State: Zip code:

Phone number: Email: Primary language:

Communication assistance: None required Spoken language Signed language AA TTY

Contact two

Lives with Applicant? ◯ Yes ◯ No ☐ Primary contact

Name: Relationship to Applicant:

Address: City: State: Zip code:

Phone number: Email: Primary language:

Communication assistance: ☐ None required ☐ Spoken language ☐ Signed language ☐ AA ☐ TTY

Contact three

Lives with Applicant? ◯ Yes ◯ No ☐ Primary contact

Name: Relationship to Applicant:

Address: City: State: Zip code:

Phone number: Email: Primary language:

Communication assistance: ☐ None required ☐ Spoken language ☐ Signed language ☐ AA ☐ 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.

Substance use

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.

Safety

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.

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

Is the Applicant now, or have they ever been a resident of an Intermediate care facility (ICF)? Yes No

Facility name Admission date Discharge date

Other agency involvement

If the Applicant is receiving services from any other city, state, or federal agencies, fill out the following information.

Agency name

Contact person

Phone number

Email

Agency name

Contact person

Phone number

Email

Applicant's professional relationships

List any current professionals (e.g. doctors, school representatives, therapists, service providers, etc.).

Type of professional

Name

Phone number

Email

Name

Phone number

Email

Type of professional

Court orders

If the Applicant is currently affected by any court orders, list the order below and provide a copy.

Order type: Date signed:

Order type: Date signed:

Order type: Date signed:

Applicant's benefits

If the Applicant receives any financial benefits, fill out the following information.

Benefit type

Amount

Frequency received

Benefit type

Amount

Frequency received

Applicant's health insurance

Choose all that apply.

- ☐ Medicaid Identification number:
- ☐ Medicare Identification number:
- ☐ Private insurance:

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

Request for ICD-10 code

Form 18 Version Date: July, 2026

PRIVACY NOTICE: The information you provide on this form will be used to determine eligibility for division services. It will be used only by DHHS, if needed, or by a person or party contracted with DHHS. Without this information, we cannot make a determination about your eligibility. This data is part of record series 15376.

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. The form must be completed and signed by a medical professional whose scope of licensure includes the ability to render diagnoses. 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.

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

Email: dspdintake@utah.gov

Fax: 801-538-4279

Applicant information

Name: DOB:

Medical professional information

Name: Phone number:

Credentials:

Diagnosis:

Certification

It is my conclusion that the Applicant meets the following primary ICD-10 code(s) and diagnosis(es):

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:

Department *of* Health & Human Services | Services for People with Disabilities

Authorization to furnish information

Form 1-2 Version Date: July 2026

PRIVACY NOTICE: The information you provide on this form will be used to determine eligibility for division services. It will be used only by DHHS, if needed, or by a person or party contracted with DHHS. Without this information, we cannot make a determination about your eligibility. This data is part of record series 15376.

Name: _____ Date of birth: _____

The following have my permission to disclose my protected health information:

- ☐ School District: _____
- ☐ Vocational Rehabilitation: _____
- ☐ Mental Health Provider: _____
- ☐ Physician: _____
- ☐ Other: _____

You are hereby authorized to release to the **Department of Health & Human Services Division of Services for People with Disabilities (DHHS DSPD)** or its authorized representatives, verbally or in any written form, any information you have regarding the following subjects:

☐ Developmental testing	☐ Inpatient records	☐ Vocational testing
☐ Psychological/cognitive tests	☐ Brain injury records	☐ IEP/educational testing
☐ Out patient records	☐ Physical examination records	☐ Other: _____

Please include records from _____ to _____

(If the information released relates to drug or alcohol abuse, the records are protected by federal confidentiality laws and you are prohibited from making further disclosures of this information without the specific written authorization of the person of whom it pertains or as permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal law restricts using drug or alcohol abuse information for criminal investigation or prosecution.)

The purpose of this disclosure is to establish eligibility for DSPD services. Disclosure Expiration Date:

- I understand that I may refuse to sign this Authorization, and my health care provider cannot refuse to provide treatment, payment, or deny eligibility for benefits based upon my refusal.
- I understand that I may revoke this authorization in writing at any time. I understand that my revocation is not effective until received by the health care provider. My revocation is not effective to the extent the health care provider already released information in reliance on this authorization.
- I understand that federal privacy laws may no longer protect information released to DSPD and the information may be re-disclosed.
- I understand that this information is required by the Department of Health & Human Services, Division of Services for People with Disabilities to determine eligibility.

I, the Individual and/or Authorized Personal Representative, understand that by signing below am requesting the Division of Services for People with Disabilities collect information about me to see if I am eligible for services.

Signature: _____ Date: _____

Signer is: ◯ the individual named above ◯ the individual's legal guardian

Authorized personal representative's name: _____

Intake frequently asked questions

Acquired brain injury (ABI)

Question: How does DSPD determine if my case is eligible for services?

Answer: DSPD uses your documents to decide if you are eligible for services. To be eligible for services, you must have a disability for which DSPD provides services. Your intake worker looks for an eligible disability in your documents.

The Intake Checklist lists the documents that we need to review. The Checklist is included in your intake packet. DSPD may ask you for more or different documents.

Question: How long do I have to turn in the documents to DSPD?

Answer: You have 90 days to complete the intake packet and send in the eligibility documents. The 90 days begins when your intake worker sends you the intake packet or you start intake through MySTEPS. Your intake worker can help you gather documents.

Question: What happens if I don't turn in all of the documents within 90 days?

Answer: DSPD switches your case to 'inactive' if we don't have the documents that we need. Your intake worker will send a letter that tells you that the 90 days passed. Contact your intake worker to change your case back to 'active' if you have your documents ready.

Question: What documents are needed?

Answer: Here is a list and explanation of the documents that DSPD needs for eligibility. The Intake Checklist lists the documents that we need to review. The Checklist is included in your intake packet.

A. Social history

   i. The social history is included in the intake packet and is available in MySTEPS. DSPD can review other documents before you finish the social history. DSPD needs the social history to decide if you are eligible.

B. Social security card and birth certificate

   i. DSPD can review other documents before we have your social security card and birth certificate. DSPD needs both documents to decide if you are eligible. DSPD can help you ask for a new card or certificate if you cannot find them.

C. Medical records

   i. DSPD only needs records and information related to your disability. We do not require every record that your doctor has on file.

   ii. We will send you a Form 18 to document your diagnosis. The Form 18 is completed by a medical professional whose scope of licensure includes the ability to diagnose.

   iii. We can use a letter from your healthcare provider if it has the information that we need. We need to know the patient's name, a diagnosis, a current ICD diagnosis code, and a description of functional limitations. Your healthcare provider will know what the ICD diagnosis code is. The letter must be signed and dated by your healthcare provider.

D. Form 1-2 authorization to furnish information and release from liability

   i. The Form 1-2 allows your intake worker to ask for your protected school and medical information. Send us this form if you want help gathering your documents. We cannot ask your school, physician, or service provider for your protected information without a signed form. The Form 1-2 is included in the intake packet. Contact your intake worker if you need another copy of the form.

   ii. Please list the name and phone number of each place that your intake worker can ask for information.

E. Needs assessment questionnaire (NAQ)

   i. The NAQ is a DSPD assessment you complete with your intake worker. DSPD needs to review all of your documents before we complete the NAQ. Your intake worker will contact you about the NAQ.

   ii. DSPD uses the NAQ results to calculate your critical need score.

F. Comprehensive brain injury assessment (CBIA)

   i. The CBIA is a DSPD assessment that is done with your intake worker. DSPD needs to review all of your documents before we complete the CBIA. Your intake worker will contact you about the CBIA.

   ii. DSPD uses the CBIA to identify your functional limitations.

Question: Does the person applying need to register to vote to be eligible for DSPD Services?

Answer: No. DSPD does not use voter registration to decide eligibility.

Question: What happens after all the documents are submitted?

Answer: First, your intake worker reviews all of your documents. Then, they contact you to schedule two DSPD assessments. The Needs Assessment Questionnaire (NAQ) and the Comprehensive Brain Injury Assessment (CBIA) are part of the eligibility process.

Question: How will I know when a decision has been made?

Answer: DSPD will send you a letter called the Notice of Agency Action (NAA). The NAA tells you if you are eligible or not eligible for DSPD services.

Question: What happens if I am not eligible?

Answer: You will be sent a letter called the Notice of Agency Action (NAA). The NAA tells you that you are not eligible for services. If you want to, you can appeal DSPD's decision. An appeal tells DSPD that you do not agree with the decision. Attached to the NAA is a hearing request form. Follow the directions on the hearing request form to begin the appeal process. The hearing request form must be returned to DSPD within 30 days of the postmark on the NAA letter envelope. Contact your intake worker if you have questions about the hearing request form or the appeal process.

Question: What happens if I am eligible?

Answer: You will be sent a letter called the Notice of Agency Action (NAA). The NAA tells you that you are eligible for services.

Question: How long will I be on the waiting list?

Answer: Wait times vary based on each person's assessed need and available funds. The waiting list ranks people by their critical

need score. Your critical need score comes from the NAQ. Funding is offered to people with the most critical needs, not on a first-come-first-serve basis. Contact your intake worker or visit the DSPD website for more information about the waiting list.

Question: How does DSPD follow-up with people on the waiting list?

Answer: DSPD will call you every year. When we call, we will ask you survey questions and update your NAQ. We use the survey to confirm that you still want our services. If DSPD cannot complete your survey, we will remove you from the waiting list. Call intake at 1-877-568-0084 if you find that you are no longer on the waiting list.

You can contact your waiting list worker at any time to update your need assessment or check on your case.

Question: What happens when I come off the waiting list?

Answer: Your DSPD waiting list worker will confirm eligibility by reviewing your eligibility documents. You may need to update your documents. Updating your eligibility documents can be a lot like the intake process. Your waiting list worker will tell you if DSPD needs new documents from you. Tell your waiting list worker if you need help getting new documents.

After we update your documents, DSPD will confirm that funding is available and will send you information to help you choose a support coordinator and service provider(s). A support coordinator helps you find services you choose and track your budget. Your state support coordinator will help you set-up a service plan.

Other Information

Medicaid information

Visit: medicaid.utah.gov.

Skilled Nursing Facility (SNF) information

Visit: https://medicaid.utah.gov/medicaid-long-term-care-and-waiver-programs/.

DSPD information

Visit dspd.utah.gov.

Contact your intake worker.