Utah Department of
Health & Human
Services

Intake checklist: physical disabilities

Version Date: April 2025

PRIVACY NOTICE: The information you provide on this form will be used to determine eligibilty for divsion 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 eligibility 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 Minimum Data Set–Home and Community.

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

Eligibility documents

Required for everyone	May be needed to determine your eligibility
Form 1-1: Request for Determination of Eligibility for Services	Copy of Medicaid Card (if not applicable, note in the social history.)
Copy of Social Security Card	Form 1-2: Authorization to Furnish Information and Release from Liability
Copy of birth certificate	Form 18: *Request for ICD code* (completed by a medical professional whose scope of licensure includes the ability to render diagnoses).
Social history	
Medical records (relevant documentation of the diagnosis)	
Form 3-1: Physical Disabilities Application (part A completed by the applicant. Part B completed by a medical professional whose scope of licensure includes the ability to render diagnoses).	

Send documents by email, mail, or fax

Mail: Division of Services for People with Disabilities
ATTN: PD Intake
288 N 1460 W
Salt Lake City, UT 84116

Fax: 801-538-4279

Email: dspd_physicaldisability_intake@utah.gov

Utah Department of Health & Human Services

Request for determination of eligibility for services

Form 1-1 PD Version Date: March 2025

PRIVACY NOTICE: The information you provide will be used to determine eligibility for division services. It will only be used by DHHS and, if needed, by a person or party contracted with DHHS. Without this data, we cannot make a determination. 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: PD Intake
288 N 1460 W
SLC, UT 84116

Fax: 801-538-4279

Email: dspd_physicaldisability intake@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

Intake social history

Form 824-I
Version Date: April 2025

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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.

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 use

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

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

Type of professional

Name

Phone number

Email

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:

Utah Department of
Health & Human
Services

Application for physical disabilities services

Part A – completed by the applicant

Form 3-1 Version: April 2025

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Introduction

Physical disabilities services are only delivered through the self-administered services (SAS) model. The SAS model supports an individual with a disability in self-directing the personal assistance services they receive through the physical disabilities program. It is important to understand:

A. You are the employer. You are responsible for hiring and managing your own personal attendants, which includes employee selection, scheduling, termination, performance evaluations, arranging back-up coverage, and submitting time sheets. Talk to your Nurse Coordinator about using the Consumer Preparation Service to learn more about your employer responsibilities.

B. You will train your personal attendants on how and when you need assistance, changing levels in personal needs, grievance procedures, emergency coverage, exploitation, and abuse.

Applicant information

Name: Date of birth: Over 18: Yes No

Address (Include Zip Code):

Social security number: Phone: Email:

To qualify for physical disabilitities services, you must have a physical impairment that has resulted in the functional loss of two or more limbs. Please describe the nature of your disability:

Is your disability permanent? Yes No Date of onset:

If your disability is temporary, what is the expected duration of the disability?:

Do you have a Medicaid card? Yes No Pending

What is your gross monthly income? $

Do you use home health aide services? Yes No

If yes, how many visits? per day or per week

Do you currently have a personal attendant not from a home health agency? Yes No

If yes, how many hours? per day or per week

What is the name of your personal attendant (if you indicated that you have one)?

Select all activities of daily living that you require assistance with:

- Dressing
- Eating
- Transfers to or from a bath/shower or vehicle
- Ventilator, Catheter Care, Suctioning
- Overnight Attention
- Grooming
- Laundry
- Cooking
- Grocery Shopping

Please describe your expectations of how this program will help you:

Signature

I certify that the information provided in this application is true and accurate. I also agree to comply with all program requirements.

Applicant Signature: Date:

Send completed form by email, mail, or fax.

Mail: Division of Services for People with Disabilities
ATTN: PD Intake
288 N 1460 W
SLC, UT 84116

Email: dspd_physicaldisability intake@utah.gov

Fax: 801-538-4279

Utah Department of
Health & Human
Services

Application for physical disabilities services

Part B – completed by the medical professional

Form 3-1
Version: April 2025

Introduction

Your patient is applying for physical disabilities services available through the Department of Health & Human Services, Division of Services for People with Disabilities (DHHS, DSPD). Physical disabilities services means hands-on care, of both a medical (to the extent permitted by State law) and non-medical services of a supportive nature, specific to the needs of an adult with a physical disability (assistance with activities of daily living and personal care). The information you provide will assist the DSPD Nurse Coordinator with making a determination about your patient's eligibility for services. Feel free to engage your patient in an open dialogue while filling out the form.

Medical professional information

Name: Phone number:

Address (Include Zip Code):

Patient information

Patient name:

ICD 10 Code: Definition:

Patient is medically stable. Yes No

Patient has a functional loss of two or more limbs. Yes No

Patient's functional loss of two or more limbs is permanent. Yes No

Patient's functional loss of two or more limbs is expected to last at least 12 months. Yes No

Self-administered assessment

Self-Administered Services (SAS) is a service delivery model that allows an individual with a disability to self-direct the personal assistance services they receive through the physical disabilities program. Physical disabilities services may only be delivered through self-administered services.

This means that in order to be eligible for Physical Disabilities Services, your patient must be able to:

C. hire, train and supervise their own personal attendant(s);

D. determine how and when services are provided; and

E. instruct the personal attendant as to how and when assistance is needed.

If you have concerns about your patient's ability to complete these tasks, please state them in the "Comments" section below. This assessment is intended to identify any issues of concern or deficits that may interfere with the patient's ability to self-direct the physical disabilities services needed.

I certify that the patient, based on the assessment above:

Is able to self-administer their program.

Is not able to self-administer their program.

Comments

Include any additional information or concerns.

Signature

I certify that the information provided in this application is true and accurate to the best of my knowledge.

Medical professional signature: Date:

Send completed form by email, mail, or fax.

Mail: Division of Services for
People with Disabilities
ATTN: PD Intake
288 N 1460 W
SLC, UT 84116

Email: dspd_physicaldisability_intake@utah.gov

Fax: 801-538-4279

Utah Department of Health & Human Services

Authorization to furnish information and release from liability

Form 1-2 Version Date: March 2025

PRIVACY NOTICE: The information you provide on this form will be used to determine eligibilty for divsion 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
Mental health provider
Other
Vocational Rehabilitation
Physician

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
Outpatient 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.

I, the Individual and/or Authorized Personal Representative, understand that by signing below am requesting the Division of Services for People with Disabilities to 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:

Utah Department of
Health & Human
Services

Request for ICD-10 code

Form 18 Version Date: April 2025

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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: PD Intake
288 N 1460 W
Price, UT 84501

Email: dspd_physicaldisability_intake@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: Date:

Utah Department of
Health & Human
Services

Intake frequently asked questions

Physical disabilities (PD)

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 nurse coordinator 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 nurse coordinator sends you the intake packet or you start intake through MySTEPS. Your nurse coordinator 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 nurse coordinator will send a letter that tells you that the 90 days passed. Contact your nurse coordinator 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.

F. 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.

G. 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.

H. 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.

I. Form 3-1 physical disabilities application

i. Part A is filled out by you.

ii. Part B is completed by a medical professional whose scope of licensure includes the ability to diagnose.

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

   i. The Form 1-2 allows your nurse coordinator 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 nurse coordinator if you need another copy of the form.

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

K. Needs assessment questionnaire (NAQ)

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

   ii. DSPD uses the NAQ results for two purposes. First, to identify your functional limitations. And, second, to calculate your critical need score.

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 nurse coordinator reviews all of your documents. Then, they contact you to schedule a DSPD assessment. The Needs Assessment Questionnaire (NAQ) is 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 letter envelope. Contact your nurse coordinator 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 nurse coordinator 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 nurse coordinator 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 nurse coordinator will look at all of your eligibility documents. You may need to update your documents. Updating your eligibility documents can be a lot like the intake process. Your nurse coordinator will tell you if DSPD needs new documents from you. Tell your nurse coordinator if you need help getting new documents. After we update your documents, DSPD will confirm that funding is available for you to enter services.

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 nurse coordinator.