State of Illinois
Illinois Department on Aging

CARE COORDINATION UNIT – CHOICES FOR CARE SCREENING VERIFICATION FORM

HOSPITAL REFERRAL FOR SCREEN

Date of Referral for Screen: Click here to enter a date.	Time of Referral: ☐ a.m. ☐ p.m.
Date of Screen Completion: Click here to enter a date.	Time of Completion: ☐ a.m. ☐ p.m.
Name of Hospital:	
Address/City:	Zip:
Patient's Name:	
Date of Birth:	Social Security Number:
DON Score:	RIN (if available):
☐ Referred to DMH PAS Agent ☐ Referred to DDD ISC Agency ☐ Referred to Both	

DISCHARGE FROM HOSPITAL

Name of Nursing Facility/Supportive Living Program Provider:	
Address/City:	Zip:
*Date/Time Required Forms sent to NF/SLP by the CCU: Click here to enter a date.	
*(If upon completion of the Screen and the patient is choosing/requiring a NF/SLP – and the location and/or date of discharge is unknown – the Hospital Discharge Planner must complete date of discharge, location and transmit this information to the CCU noted below) Date of Discharge: Click here to enter a date.	
Name of Hospital Discharge Planner:	
Phone Number:	FAX Number:

CCU CONTACT

Name of Care Coordinator Completing Screen:	
Care Coordination Unit:	
Phone Number:	FAX Number: