



When further information is needed to determine a participant's ability to self-direct their Consumer-Directed Services, the Healthcare Professional Inquiry form shall be sent to a participant's healthcare professional, such as a Physician, Registered Nurse, Nurse Practitioner, and Physician Assistant. After the assessor has administered the St. Louis University Mental Status (SLUMS) examination and the Self-Direction Assessment questions and there continues to be concerns with the participant's ability to self-direct, the assessor shall send the Healthcare Professional Inquiry form.

The assessor shall contact the healthcare professional to obtain the appropriate fax number and inform them Division of Senior and Disability Services (DSDS) staff will be faxing this form to obtain the opinion of the healthcare professional.

### NUMBER OF COPIES

One copy of the form shall be completed per healthcare professional.

### INSTRUCTIONS

**TO:** Enter the healthcare professional's name and mailing address.

**PARTICIPANT NAME:** Enter the participant's name.

**DCN:** Enter the participant's Departmental Client Number (DCN).

**DATE OF BIRTH:** Enter the participant's date of birth.

**CHECKBOX SECTION:** The healthcare professional shall answer the question about the participant's ability to self-direct by marking YES or NO.

- If the answer is NO, the healthcare professional is encouraged to provide an explanation of the reason in the space provided.

**NAME:** The healthcare professional completing the form shall print their name.

**DATE:** The healthcare professional completing the form shall enter the date they signed the form.

**SIGNATURE:** The healthcare professional completing the form shall sign their name.

**ASSESSOR COMMENTS:** This space shall be utilized by the assessor to relay other applicable information to the healthcare professional from the assessor when necessary.

**ASSESSOR SIGNATURE:** The assessor completing the form shall sign their name.

**ASSESSOR NAME:** The assessor completing the form shall print their name.

**TELEPHONE:** Enter the telephone number of the assessor.

**DATE FAXED:** Enter the date the assessor faxed the form to the healthcare professional.

**MAILING ADDRESS:** Enter the mailing address of the assessor.

**FAX NUMBER:** Enter the fax number of the assessor.

A copy of the Healthcare Professional Inquiry form shall be scanned into the participant's electronic case record.