



for office use:

Member Name: _____

DOB: _____

Medicaid: _____

Referral Application for HCBS Waiver Program

Program: (circle):

Residential Services:

Vocational Services: (Story County only)

ID Waiver

Daily – 24 hour

The Center – Enclave

BI Waiver

Daily – 24 hour for Higher Medical Needs

The Center – Day Hab - Community Integration

Habilitation

Hourly

General Information:

Name of person being referred: _____ Date of referral: _____

Completed by: (circle one) Case Manager Self Family Member Other: _____

County of Legal Settlement: _____

Social Security Number: _____ Date of Birth: ____/____/____

Referring Person: _____

Agency: _____

Address: _____

Phone: _____

Email Address: _____

Insurance Information:

Medicare Number: _____ Medicaid Number: _____

Other Insurance: _____

Managed Care Organization: _____

MCO Policy Number: _____

Primary Diagnosis & ICD-10 Code: _____

Secondary Diagnosis & ICD-10 Code: _____

Current Living Arrangements:

(Name of Facility or Provider, if applicable)

(Street address, apartment #)

(City, state, and zip code)

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(Current phone number)

(Contact Person / Phone Number / Email address)

Guardianship status:

Does this person have a guardian: ☐ Yes ☐ No

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Service Needs:

Level of service: ☐ Daily Site ☐ Hourly: Projected # of 15 min units/month _____

Required level of supervision: _____ Preferred number of roommates: _____

Financial Information:

Does this person receive SSI/SSDI/SS (please note type): ☐ Yes ☐ No _____

SSI Amount: _____ If not, has application been made: ☐ Yes ☐ No Date applied: _____

SSDI Amount: _____ If not, has application been made: ☐ Yes ☐ No Date applied: _____

SS Amount: _____ If not, has application been made: ☐ Yes ☐ No Date applied: _____

Other income amount: _____ Source: _____

Does this person receive foodstamps: ☐ Yes ☐ No

If not, has application been made: ☐ Yes ☐ No Date applied: _____

Other sources of income, e.g. pension, VA, trust fund, etc.

Source

Amount

Does this person have a representative payee? ☐ Yes ☐ No _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____



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Does this person have a conservator? ☐ Yes ☐ No _____

Name: _____

Home Phone: _____

Address: _____ Work Phone: _____

Commitment Status:

Is this person under civil commitment? ☐ Yes ☐ No

Briefly describe type of commitment,

etc.: _____

Miscellaneous Legal Information:

Is this person involved in any pending civil or criminal legal actions: ☐ Yes ☐ No

Briefly describe, e.g., scheduled commitment hearing, divorce or custody issues, pending or unresolved criminal charges, legal probation,

etc. _____

Substance Abuse/Use History:

Describe Previous Services Received:



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Current Service Involvements:

Potential Challenging Behaviors:

Potential Skill Deficits:

Significant Medical Conditions: (illnesses, hospitalizations, past & current drug therapies, special diets, etc.)

Medications:

Mobility Issues: (adaptive equipment, wheelchairs, lift devices, level of assistance needed, etc.)



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Other Documentation Needed:

- Current Service Plan
- Social History, as current as possible.
- Records of current hospitalizations, if applicable, i.e., "History & Physical" or equivalent.
- Psychological Evaluation – most recent report
- Assessment Tools appropriate to the service requested, including the SIS assessment for ID and the Inter-Rai for BI
- Legal documents, e.g., guardianship or commitment papers, restraining orders, etc. (Note: Will be required if the person is accepted for placement)
- A copy of form 1645 (verification of eligibility for TXIX) if the member is not yet approved for TXIX

Mainstream Living complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 1-888-808-9008. PIN 67357241