



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: _____



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Current Living Arrangements

(Name of Facility or Provider, if applicable)

(Street address, apartment #)

(City, state, and zip code)

(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

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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



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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: _____

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.: _____

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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. _____

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Substance Abuse/Use History:



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Describe Previous Services Received:

Current Service Involvements:

Potential Challenging Behaviors:

Potential Skill Deficits:

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



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Medications:

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

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