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____________________

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 food stamps: ☐ Yes ☐ No

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

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

<u>Source</u> <u>Amount</u>

_________________________________ _______________________

_________________________________ _______________________

_________________________________ ______________________________________

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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.:

____

____

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:

____

____

____

Current Service Involvements:

____

____

____

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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.)*

____
____
____

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