This form should be used for group home and/or Intermediate Care Facility (ICF) requests Submit Referral to [Residential.Referrals@apdcares.org](mailto:Residential.Referrals@apdcares.org)

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| **CONSUMER INFORMATION** | | | | | | | | | | | | | | | |
| **First Name:** | | | Client First Name | | | | | | **Last Name:** | Client Last Name | | | | **MI:** | MI |
| **iConnect #:** | | | Client’s iConnect | | | | | | **Referral Date:** | Click or tap here to enter text. | | | | | |
| **Region:** | | | Choose an item. | | | | | | **County:** | Click or tap here to enter text. | | | | | |
| **DOB:** | | | Click or tap here to enter text. | | | | | |  | **Female** |  |  | **Male** | |  |
| **Height:** | | Feet: | | Feet | Inches: | Inches | | **Weight:** | | | Click or tap here to enter text. | | | | |
|  | Minor | |  | |  | |  | | Deemed Incompetent | | | |  | CDC+ |  |
|  | Adopted (*Minors only*) | | | | | |  | | 393.11 (Involuntary Commitment) | | | |  |  |  |
|  | Substance Abuse Issues | | | | | |  | | Registered Sex Offender | |  | |  |  |  |
|  | Under Active Court Order | | | | | |  | | Significant Additional Needs (SAN) Request Submitted? | | | | | | |
| **Qualifying Diagnosis:** | | | | | Click or tap here to enter text. | | | | | | | | | | |
| **Mental Health Diagnosis:** | | | | | Click or tap here to enter text. | | | | | | | | | | |
| **Medical Health Diagnosis:** | | | | | Click or tap here to enter text. | | | | | | | | | | |
| **Additional Health Issue(s):** | | | | | | | | | | | | | | | |
| Cardiovascular System: (heart, arteries, blood vessels)  Endocrine System: (thyroid, pancreas, parathyroid, adrenals, pituitary, hypothalamus, thymus, ovaries, testes)  Hematology/Immune System: (blood, spleen, lymph glands, bone marrow)  Musculoskeletal System: (connective tissue, muscles, bones)  Respiratory System: (nose, trachea, lungs) | | | | | | | | | Digestive System: (mouth, teeth, stomach, liver, gall bladder, bowel)  Genitourinary System: reproductive/sexual organs, kidney, bladder)  Integumentary System: (skin, connective tissue, mucus membrane)  Neurological System: (brain, spinal cord)  Diagnosed Genetic Disorder(s)  Other Chronic Health Concerns | | | | | | |
| **Enter Details for Other Chronic Health Concerns:** Click or tap here to enter text. | | | | | | | | | | | | | | | |

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| **LEGAL REPRESENTATIVE** | | | | | | | |
| **First Name:** | Click or tap here to enter text. | | **Last Name:** | Click or tap here to enter text. | | **MI:** | MI |
| **Contact Type:** | Choose an item. | | **Cell #:** | Click or tap here to enter text. | | | |
| **Home #:** | Click or tap here to enter text. | | **Email:** | Click or tap here to enter text. | | | |
| **Address Ln 1:** | Click or tap here to enter text. | | **Address Ln 2:** | Click or tap here to enter text. | | | |
| **City:** | Click or tap here to enter text. | | **State:** | State | **ZIP:** | ZIP | |
| **If Contact Type is Other, provide details:** | |  | | | | | |

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| **COORDINATOR INFORMATION** | | | |
| **Coordinator Type:** | Choose an item. | **Email:** |  |
| **First Name:** | Click or tap here to enter text. | **Last Name:** | Click or tap here to enter text. |
| **Office #:** | Click or tap here to enter text. | **Cell #:** | Click or tap here to enter text. |

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| **CURRENT RESIDENTIAL SETTING** | | | | | | |
| **Current Residential Setting:** | Choose an item. | | **Current Approved**  **Residential Habilitation Level:** | | | Choose an item. |
| **Behavior Analyst Name:** | Click or tap here to enter text. | | **Reason for New**  **Placement Request:** | | | Choose an item. |
| **Placement Request Note:** | Click or tap here to enter text. | | | | | |
| **Behavior Assessment**  **Status:**  *(For IB or BF Clients only)* |  | Has NOT Been Requested |  |  | Has Been Requested | |
|  | Behavior Assessment Scheduled | |  | Behavior Assessment Available | |
|  | LRC Review Scheduled |  |  | LRC Recommendation Available | |

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| **HISTORY OF PRIOR PLACEMENTS** *(Include current placement and previous two years)* |
| Click or tap here to enter text. |

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| **ADAPTIVE SKILLS** | | | |
| **Ability to Evacuate:** | Choose an item. | **Receptive Communications:** | Choose an item. |
| **Expressive Communications:** | Choose an item. | **Eating:** | Choose an item. |
| **Dressing:** | Choose an item. | **Toileting:** | Choose an item. |
| **Personal Hygiene:** | Choose an item. |  |  |
| **Adaptive Equipment:**  *List equipment and include pertinent details.* | Click or tap here to enter text. | | |

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| **NEEDS AND ACCOMODATIONS** | | | | | | | | | |
| **Vision:** | Choose an item. | | | | | **Hearing:** | | Choose an item. | |
| **Select all applicable**  **needs:** |  |  | | Allergies |  |  | Limited Ambulation |  | Aspiration Precaution |
|  |  | | Behavioral Issues | |  | Chronic/ Important Issues |  | Nursing |
|  |  | | Non-Ambulatory | |  | Special Diet |  | Other Needs / Concerns |
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| **NEEDS AND ACCOMMODATION DETAILS** | | | | | | | | | |
| **Allergy Details:** | | | Click or tap here to enter text. | | | | | | |
| **Ambulation Details:** | | | Click or tap here to enter text. | | | | | | |
| **Behavioral Issue(s)**  **Details:** | | | Click or tap here to enter text. | | | | | | |
| **Behavioral Service**  **Plan in Place?** | | | Choose an item. | | | | | | |
| **Nursing Services**  **in Place?** | | | Choose an item. | | | | | | |
| **Nursing Details:**  *List current skilled nursing needs* | | | Click or tap here to enter text. | | | | | | |
| **Special Diet Details:** | | | Click or tap here to enter text. | | | | | | |
| **Aspiration Precaution Details:** | | | Click or tap here to enter text. | | | | | | |

**Additional needs and accommodation details:** Click or tap here to enter text.

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| **Preferred Location(s):**  **If group home or ICF/DD location is known, please enter the information below** | |
| **Choice 1: Location Type:** | Choose an item. |
| **Location Name:** | Click or tap here to enter text. |
| **Location Address:** | Click or tap here to enter text. |
| **Choice 2: Location Type:** | Choose an item. |
| **Location Name:** | Click or tap here to enter text. |
| **Location Address:** | Click or tap here to enter text. |

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| **APPROVED RESIDENTIAL HABILITATION REQUEST** | | | | | | | | | | | | | | |
| **Approved Residential**  **Setting:** | | | Choose an item. | | | | | **Approved Residential**  **Habilitation level:** | | | | Choose an item. | | |
| **Statewide?** |  | | | | | | | | | | | | | |
| **Central:** | **All Counties?** | | |  | | | | | | | | | | |
|  | Brevard | |  |  | Citrus |  | | Hardee |  | Hernando | |  | Highlands |
|  | Lake |  |  |  | Marion |  | | Orange |  | Osceola | |  | Polk |
|  | Seminole | |  |  | Sumter |  | |  |  |  | |  |  |
| **Northeast:** | **All Counties?** | | |  | | | | | | | | | | |
|  | Alachua | |  |  | Baker |  | | Bradford |  | Clay |  |  | Columbia |
|  | Dixie |  |  |  | Duval |  | | Flagler |  | Gilchrist | |  | Hamilton |
|  | Lafayette | |  |  | Levy |  | | Madison |  | Nassau |  |  | Putnam |
|  | St. Johns | |  |  | Suwannee |  | | Taylor |  | Union |  |  | Volusia |
| **Northwest:** | **All Counties?** | | |  | | | | | | | | | | |
|  | Bay |  |  |  | Calhoun |  | | Escambia |  | Franklin | |  | Gadsden |
|  | Gulf |  |  |  | Holmes |  | | Jackson |  | Jefferson | |  | Leon |
|  | Liberty |  |  |  | Okaloosa |  | | Santa Rosa |  | Wakulla | |  | Walton |
|  | Washington | | | |  |  | |  |  |  | |  |  |
| **Southeast:** | **All Counties?** | | |  | | | | | | | | | | |
|  | Broward | |  |  | Indian River |  | | Martin |  | Okeechobee | |  | Palm Beach |
|  | St. Lucie | |  |  |  |  | |  |  |  | |  |  |
| **Southern:** | **All Counties?** | | |  | | | | | | | | | | |
|  | Miami-Dade | | |  | Monroe |  |  |  |  |  |  |  |  |
| **Suncoast:** | **All Counties?** | | |  | | | | | | | | | | |
|  | Charlotte | |  |  | Collier |  | | DeSoto |  | Glades |  |  | Hendry |
|  | Hillsborough | | |  | Lee |  | | Manatee |  | Pasco |  |  | Pinellas |
|  | Sarasota | | |  |  |  | |  |  |  |  |  |  |

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| **Group Home Requests - REQUIRED ATTACHMENTS** | | | |
|  | Support Plan (required for all except CBC) |  | Shelter Order (CBC) |
|  | Behavior Assessments (for IB/BF clients only) |  | Case Plan (CBC) |
|  | LRC Recommendations (for IB/BF clients only) |  |  |
| **Group Home Requests - ADDITIONAL ATTACHMENTS** | | | |
|  | Critical Medical Reports |  | Safety Plan |
|  | Psychiatric Evaluations |  | Skills Assessments |
|  | Psychological Evaluations  Individual Education Plan (for minors) |  | Other Attachments |

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| **Intermediate Care Facility (ICF/DD) Requests** | | | | | | | | |
| ***For all ICF/DD requests:***   * *A QSI no older than 90 days is required before a signed authorization for placement can be provided.* * *Please make sure all behavioral, medical, and ambulatory information is completed in detail on this form.* | | | | | | | | |
| **QSI INFORMATION** | | | | | | | | |
| **QSI Date** | | Date | | **Overall Score** | | | | Score |
| **Functional Score** | | Score | | **Behavioral Score** | | Score | **Transfer Score** | Score |
| **Physical Score** | | Score | | **Hygiene Score** | | Score | **Self-Protection Score** | Score |
| **Currently enrolled on the Waiver:** | | | Yes  No  *If enrolled on the waiver, a disenrollment note in iConnect will be required once*  *an ICF location has accepted* | | | | | |
| **Reason for ICF/DD request:** | | | Click or tap here to enter text. | | | | | |
| **APD State Office / MCM only:**  **LEVEL OF REIMBURSEMENT:**  1  2  3 *(APD State Office approval only)*    Signature Date | | | | | | | | |
| **ICF/DD Requests - REQUIRED ATTACHMENTS** | | | | | | | | |
|  | Support Plan\* (required for all except CBC) | | | |  | Signed Choice Counseling \* (required) | | |
|  | Signed Documentation of Choice \* (required) | | | |  | Signed HCBS Waiver eligibility \* (required) | | |
|  | QSI no older than 90 days \* (required) | | | |  | \*Guardianship order or Notarized Medical Proxy \* | | |
| **Additional information is needed for Minor ICF placement requests** | | | | | | | | |
|  | Signed detailed statement - parent/guardian \*  (required) | | | |  | Other Attachments | | |

(\* Guardianship or Medical Proxy only required for individuals deemed non-competent by a court order\*)

**Other Important Details:** Click or tap here to enter text.