This form should be used for group home and/or Intermediate Care Facility (ICF) requests Submit Referral to 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 |
|  |  |  |  |  |  |  |  |
| **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 EvaluationsIndividual 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.