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| **CONSUMER INFORMATION** |
| **First Name:** | Client First Name | **Last Name:**  | Client Last Name | **MI:** | MI |
|  **PIN:** | Client’s PIN | **Ref. Date:** | Click or tap to enter a date. |
| **Region:** | Choose an item. | **County:** | Click or tap here to enter text. |
| **DOB:** | Click or tap to enter a date. |[ ]  **Female** |[ ]  **Male** |
|[ ]  Minor |[ ]  Deemed Incompetent [ ] CDC+ |
|[ ]  Adopted (Minors only) |[ ]  393.11 |
|[ ]  Substance Abuse Issues |[ ]  Registered Sex Offender |
|[ ]  Under Active Court Order |[ ]  SAN Submitted? | Submitted Date: | Enter a date. |
| **Qualifying Diagnosis:** | 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 Ph. #:** | Click or tap here to enter text. | **Email:** | Click or tap here to enter text. |
| **Addr. Line 1:** | Click or tap here to enter text. | **Addr. Line 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:** | Click or tap here to enter text. |

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

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| **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 |

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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 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. |
| **Helpful Comments:** | Click or tap here to enter text. |

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| **NEEDS AND ACCOMODATIONS** |
| **Height:** | Feet: | Feet | Inches: | Inches | **Weight:** | Click or tap here to enter text. |
| **Vision:** | Choose an item. | **Hearing:** | Choose an item. |
| **Select all applicable needs:** |[ ]  Allergies |[ ]  Ambulation |[ ]  Aspiration Precaution |
|  |[ ]  Behavioral Issues |[ ]  Chronic/ Important Issues |[ ]  Nursing |
|  |[ ]  Physical Handicaps |[ ]  Special Diet |[ ]  Other Needs / Concerns |
| **Medical Health Diagnosis:** | Click or tap here to enter text. |
| **Mental Health Diagnosis:** | Click or tap here to enter text. |

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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 Service Plan in Place?** | Choose an item. |
| **Behavioral Issue(s) Details:** | Click or tap here to enter text. |

**Chronic/ Important Issue(s) Details:**

[ ]  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.

**Additional Information that needs to be provided** (notes section will expand)**:** 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?** |[x]
|  | [ ]  | 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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| **ATTACHMENTS – Group Home Requests** |
|[ ]  Support Plan\* (required for all except CBC) |[ ]  Critical Medical Reports |
|[ ]  Individual Education Plan\* (for minors) |[ ]  Psychiatric Evaluations |
|[ ]  Case Plan\* (CBC) | [ ]  | Psychological Evaluations |
|[ ]  Shelter Order\* (CBC) | [ ]  | Safety Plan |
|[ ]  Behavior Assessments\* (for IB/BF clients only) |[ ]  Skills Assessments |
|[ ]  LRC Recommendations\* (for IB/BF clients only) |[ ]  Other Attachments |

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

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| **ATTACHMENTS – ICF/DD Requests**  |
|[ ]  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.

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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.*
 |
| **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 |