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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?** | | | |  | | | | | | | | | | | |
|  | | 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 | |