



LTSS HCBS Referral Form

This form is used by certified Conflict Free Case Managers (CFCMs) and State Social Case Workers (SCWs) to submit referrals for HCBS participants to different LTSS programs in Rhode Island including Personal Choice, Shared Living (EAD), BHDDH-DD, Medicaid Preventive (RIPIN) and other interagency and community programs and services.

NOTE:

1. Case managers should utilize the Residential Needs Assessment form for all residential or shared living referrals for I/DD participants.
2. This form should be utilized for participants receiving LTSS via FFS only.

Referred by:

Completed By: Social Caseworker CFCM IF

Name (first/last): _____

Title: _____

Agency: _____ Work Phone: _____

Work Email: _____

Referral To (Provider Agency):

Name (first/last): _____

Title: _____

Agency: _____ Work Phone: _____

Work Email: _____



Referral

1. Today's Date:														
2. Participant Name:														
First:									Last:					
3. MID#:														
4. Address:														
5. Legal Guardian/POA or Authorized Rep contact info: (name, address, phone):														
First Name:									Last Name:					
Street Address:														
Phone:														
6. Primary Language:														
7. Interpreter needed:				<input type="checkbox"/> Yes		<input type="checkbox"/> No								
8. Contact Number (name and relationship of contact person, if not self):														
9. Referral Reason:														
10. Location (area they live in and want to receive services in):														
11. Current Living Arrangement) If other, please list. If living with someone, please list who and relationship.		<input type="checkbox"/> Independent		11.SIS-A Tier Level (DD only)										
		<input type="checkbox"/> With Family		<input type="checkbox"/>	A	<input type="checkbox"/>	B	<input type="checkbox"/>	C	<input type="checkbox"/>	D	<input type="checkbox"/>	E	
		<input type="checkbox"/> Shared Living Agency (DD or EAD)		12. If participant is still in school, graduation										
		<input type="checkbox"/> Group Home		Date:										
		<input type="checkbox"/> Other												



13. LTSS Eligibility Status:									
14. Cost of Care:									
15. LTSS Eligibility Date:									
16. Level Of Care:		<input type="checkbox"/>	High	<input type="checkbox"/>	Highest				
17. Current Program Enrollment									
<input type="checkbox"/>	Assisted Living	Tier:		Room & Board					
<input type="checkbox"/>	Shared Living (EAD)	<input type="checkbox"/>	HCBS-Agency Based/Homecare (EAD)			<input type="checkbox"/>	BHDDH-DD (Please specify current services if any)		
18. Desired Services									
BHDDH-DD HCBS:				Other HCBS:					
<input type="checkbox"/>	Center-Based Day Program			<input type="checkbox"/>	Assisted Living				
<input type="checkbox"/>	Community Based Supports			<input type="checkbox"/>	HCBS-Agency Based/Homecare				
<input type="checkbox"/>	Employment Services			<input type="checkbox"/>	Shared Living (EAD)				
<input type="checkbox"/>	Fiscal Intermediary			<input type="checkbox"/>	Personal Choice (EAD)				
<input type="checkbox"/>	Respite			<input type="checkbox"/>	Other				
<input type="checkbox"/>	Support Brokerage			Selected by DHS Staff Only:					
<input type="checkbox"/>	Other			<input type="checkbox"/>	Medicaid Preventive (RIPIN)				
				<input type="checkbox"/>	CNOM (OHA)				
				<input type="checkbox"/>	PACE				
				<input type="checkbox"/>	Neighborhood INTEGRITY for Duals				
				<input type="checkbox"/>	Other				
19. Desired number of hours:									
20. Specific participant preferences (e.g., prefers male staff):									
21. Plan Start Date:					22. Service Start Date:				



23. Meet and greet requested by participant or provider & date:	
24. Documentation Attached	