Creative COMMUNITY SERVICES, INC.

because we care

Shanique direct email

Date: _____

DD INTAKE – INITIAL PHONE/EMAIL CONTACT

Individuals **REFERRAL REVIEW FORM**

Family/Guardian Contact Name: _____

Phone: _____ Email: _____

Name of Planning List Administrator or Support Coordinator: _____

DBHDD Region and/or SC Agency: _____

PLA/SC Phone: _____ Email: _____

Referral Source: _____

Individual's Name:	Age:	DOB:
Race:	Gender:	Religion:

Requested Services

☐ CRA - Host Home/CLA (circle one) ☐ CLS ☐ CAI

☐ Respite ☐ SMS ☐ SME

Wheelchair accessible home needed? ☐ No ☐ Yes

If CLS or CAI, list staffing needs: _____

_____

Requested Service Location (City/County/Rgn): _____

Funding Sources

Check One: ☐ NOW Medicaid Waiver ☐ COMP Medicaid Waiver

☐ Grant-In-Aid ☐ Other _____

Creative COMMUNITY SERVICES, INC.

because we care

Date: _____

Is an Exceptional Rate required? ☐ No ☐ Yes – behavioral, medical, SMS (circle needs)

Is Individual eligible to receive Supplemental Security Income (SSI) benefits/Medicaid? ☐ No ☐ Yes

Does he/she currently receive SSI benefits? ☐ No ☐ Yes Amount _____

Payee _____

(Name) (Relationship to Individual)

Current Services

Current Provider(s) and Services: _____

List reason for referral to CCS: _____

Location of Current Residence (City/County): _____

With whom does he/she reside? _____

Does he/she attend day program, school, or work? ☐ No ☐ Yes

Where? _____ How often? _____

Medical and Psychiatric History

List medical and mental health diagnoses: _____

_____

_____

_____

Are mental health symptoms under control with medication? ☐ No ☐ Yes

List current medications: _____

_____

_____

Creative COMMUNITY SERVICES, INC.

because we care

Date: _____

Are there any current/on-going medical concerns (incl. seizures, allergies)? ☐ No ☐ Yes

If so, list concerns and protocol for each: _____

_____

_____

Has he/she recently been hospitalized? ☐ No ☐ Yes When? _____

For what? _____

(RN may have to evaluate whether CCS can provide support)

Strengths

Method of communication (e.g. speech, sign language, communication device(s), etc.)? _____

_____

What are his/her dietary preferences? _____

_____

What does he/she like to do for fun? _____

_____

What are his/her other interests (e.g. attending church, shopping, volunteering, going out with friends, sports, animals, etc)? _____

_____

Needs

Does the Individual have a Behavior Support Plan? ☐ No ☐ Yes

List challenging behaviors: _____

_____

_____

_____

Creative COMMUNITY SERVICES, INC.

because we care

Date: _____

Successful interventions for challenging behaviors: _____

_____

_____

What support does he/she need with Instrumental/Activities of Daily Living (e.g. personal care, meal prep, med management, housekeeping, laundry, budgeting, making appointments, shopping, transport, etc)? _____

_____

_____

_____

Does he/she need nursing care? ☐ No ☐ Yes

Follow-Up

Identified Potential CCS Host Homes/Staff/Team: _____

_____

Additional Questions: _____

_____

_____

_____

Next Steps: _____

_____

_____

_____

☐ Accept Date: _____ ☐ Defer Date: _____

Reason for deferral: _____

Creative COMMUNITY SERVICES, INC.

because we care

Date: _____

Additional Notes: _____