

Referral for Admission

Date of Referral:

Requested Admission Date:

Referral Source:

Consumer Name:

Address:

Phone:

DOB:

Sex:

Race:

Height:

Weight:

Legal Guardian:

Current Placement/Caretaker & Phone Number:

Case Manager (Agency & Assigned CM):

Advocate, if any:

Direct Service Funding Source (Waiver, Special Project):

Current Approved Budget Amount and Anchor Date (if applicable):

Current DSSLA Staff Ratio Approval:

Consumer Income (include and identify all sources):

Diagnoses (including known physical conditions):

Placement History:

Any known Trauma history (Abuse/Neglect)? Be as specific as possible

Describe Social History. If a complete social history is available, please note attachment here:

Does consumer have contact/visitation arrangements with any family/significant others? If yes, please describe:

Any legal issues, past or current? If yes, please describe in detail.

Religious or Cultural Considerations:

Personal Interests (Hobbies, Sports, Music, TV, Movies etc):

Medical:

|  |  |  |  |
| --- | --- | --- | --- |
| Physical/Psychiatric Condition | Treating Provider (Name/Phone Number)  | Medication/Intervention(s) Prescribed to Treat Condition | Date of last visit?  |
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Any history of medication refusals or other medication related difficulties?

Current Pharmacy:

Does this consumer require any adaptive equipment or ADA accommodations? (Please describe)

Can this individual ambulate without assistance? If no, please describe necessary support(s).

Does this consumer have any feeding difficulties? History of choking? Special diet (liquid, pureed, mechanical soft diet, etc) :

Behavioral:

Does this consumer have a history of Mental Illness or Substance Use/Misuse? Please describe in detail.

Any history of elopement?

Sexual History\*:

|  |  |
| --- | --- |
| Is this individual sexually active/Have a consenting partner? |  |
| Identified sexual orientation? |  |
| Inappropriate sexual behaviors toward peers? |  |
| Inappropriate sexual behaviors toward staff/others? |  |
| Inappropriate sexual behavior toward children/minors? |  |
| Inappropriate sexual behavior toward animals? |  |
| Has this person ever been accused of sexual assault? |  |
| Any issues with inappropriate sexual conduct such as public masturbation, voyeurism or public exposure? |  |
| Is this person required to register as a Sex Offender? |  |

\*Please detail any responses of Yes in the space below

How does this individual communicate?

Can this consumer read or write?

Highest level of education achieved:

Does this person have an open case with DRS?

Vocational/Volunteering History:

By my signature below, I attest that the information provided is complete and accurate to the best of my knowledge

Signature of Referring Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If accepted, the following documents MUST be received/completed or waived by SBH prior to admission:

1. Legal documents to include State ID, Birth Certificate, Social Security Card, Guardianship documents, Lease (Or Residential Agreement if for a Licensed Group Home) and Medicaid/Insurance Cards.
2. Admission IDT meeting the day of admission at the latest. This needs to include a list of any previously scheduled appointments.
3. Copy of IPP that identifies all services to be provided by SBH, with approved units.
4. Copy DSSLA indicating the approved setting.
5. Proof of ability to self-fund community placement. financial situation, if residential.  If there is a payee in place, statement of available funds.
6. Application for Unmet Needs or other funding assistance programs must be completed and approved prior to admission. SBH will not provide temporary start up loans unless approval letter is provided.
7. All utilities must be available for use at admission.
8. Current training programs and data collection sheets if applicable. These will continue to be used for 30 days during the assessment period.
9. Copies of all available Psychological Evaluations, Social History Evaluations, OT/PT/Speech Evaluations, Behavior Support Plans.

DO NOT WRITE BELOW THIS LINE. THE FOLLOWING SECTION IS TO BE COMPLETED BY SBH EVALUATORS

Date of Interview \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Virtual? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interview Team Members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Observations:

Recommendation:

Approved\_\_\_\_\_Denied\_\_\_\_\_\_Waitlist\_\_\_\_\_\_

Projected Admission Date, Pending receipt of required items. \_\_\_\_\_\_\_\_\_\_\_\_

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Director of Operations Director of Nursing