Ohio Department of Developmental Disabilities

Pre-Admission Counseling Referral Form

For individuals seeking new admission to facilities with nine beds or more. Not for transfers.

Individual Name		Birth Date	
Street		City	
County of Residence	<blank>	Zip	
Medicaid Number		SSN	
Home Phone		Cell Phone	

Guardian Information (If, applicable)

Guardian Name			
Street		City	
County	<blank>	Zip	
Phone number		Cell Phone	
Email			
I verify that I am considering accepting the next available placement opportunity at:			
Individual/Guardian Signature			Date

Proposed ICF Provider Information

ICF Name		Certified Capacity of ICF		Medicaid Provider No.	
Contact Person		Phone No.			
Street		Email			
City		Anticipated Vacancy Date			
County	<blank>	Date of Referral to County Board			
Zip					

I verify that the individual listed above is being considered for the vacancy date specified.	
Signature of ICF Representative	Date

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Name of County Board Representative			Select County Board	<blank>
Date Referral Received		Date of Interview		

Name and relationship of those attending the meeting. *Face-to-face interview with individual seeking services is required.*

Current Residence Type	Other	Other (describe below)
Current Funding Type check all that apply	☐ Medicaid (facility) ☐ Medicaid (waiver) ☐ CB funding ☐ None ☐ Other community resources (describe below)	
Other (description)		

How did you learn about this opportunity to move to an ICF?

Primary reason for considering ICF admission (Please select all that apply)
☐ Caregiver is no longer able to meet behavioral needs ☐ Caregiver no longer able to meet physical support needs ☐ Caregiver is no longer available to provide supports (relocation, death, etc.) ☐ Has new or increasing nursing needs ☐ Prefers option of “bundled” services afforded by an ICF ☐ Requires accessible living environment ☐ Other (explain below)

If Other(describe)	

List the person’s preference in the four areas below.
1. With whom does the person want to live?

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2. What work or other valued activity does the person want to do?

3. In what social, leisure, religious or other activities does the person want to participate?

4. With whom does the person want to participate in the activities listed above?

	Supported currently provided by	Is new or additional support needed?
Hands on assistance with care	<blank>	<blank>
Transportation	<blank>	<blank>
Day services	<blank>	<blank>
Employment services	<blank>	<blank>
Respite or caregiver relief	<blank>	<blank>
Adaptive equipment	<blank>	<blank>
Home modifications	<blank>	<blank>
Assistance with medications	<blank>	<blank>
Other nursing needs	<blank>	<blank>
Therapy <blank>	<blank>	<blank>
Prevention of harm to self	<blank>	<blank>
Prevention of harm to others	<blank>	<blank>

What strengths or resources does the person have that could contribute to his or her success in their community?

What are the barriers to the person remaining in the current setting/residence? *Select all that apply.*		
☐ Lack of willing or qualified providers	☐ Requires change of residence	☐ Other

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If a change in residence is required list the reasons.
State or list previous or proposed efforts to remove the barriers noted above. For each proposed effort, list person responsible for the action step and proposed date of completion.
What supports were in place before the referral and what were the reasons they were not successful?
List all community options discussed with the person.

The following documents were provided to the individual/guardian.		
☐ ICFs and Waivers: What is the Difference?	☐ Thinking about Moving?	☐ Comparing DODD Waivers
☐ What to Expect if . . .?	☐ Frequently Asked Questions	

Optional documents	
☐ What is a waiver	☐ What is an SSA
☐ What is a QIDP	
☐ Other:	

Upon review of available options, the person prefers to proceed with	☐ ICF ☐ HCBS	Date sent to DODD	
Describe reason(s) why this option was chosen			