

Missouri Department of Mental Health Mental Retardation/Developmental Disabilities Consumer Residential Referral Form

Consumer Identification

Consumer Name: _____ Client ID (Statewide ID): _____ Date of Referral: _____

About the Transition

Transition Type (Required - Check Only One)

- Community Setting to Hab Center (Long Term)
- Community Setting to Hab Center (Short Term)
- DMH Placement to Natural Home
- Hab Center Community Res to Community Provider
- Habilitation Center to Community Provider
- Habilitation Center to DMH CPS
- Habilitation Center to Habilitation Center
- Move within Community (Provider Change)
- Natural Home to Community Provider
- Nursing Home to Community Provider
- *Other Unspecified Setting to Community Provider

* Example: Children's Treatment Home, Residential Care Facility

Olmstead? Yes No

Current Residence (Check Only One)

- Correctional Unit
- Family Living Arrangement (FLA)
- Foster Home
- Group Home
- Habilitation Center – Privately Operated
- Habilitation Center – State Operated
- Homeless
- Hospital – Medical
- Hospital – Psychiatric
- Individual Supported Living (ISL)
- Intermediate Care Facility/MR (ICF/MR)
- Natural Home
- Nursing Home
- Other Unspecified Community Setting
- Residential Care Facility (RCF)
- Supported Living Arrangement (SLA)
- Treatment Center, Children's

To DMH Facility (Required – All That Apply)

- | | |
|--|---|
| <input type="checkbox"/> 011 Albany Regional Center Primary? | <input type="checkbox"/> 019 Sikeston Regional Center Primary? |
| <input type="checkbox"/> 012 Kirksville Regional Center Primary? | <input type="checkbox"/> 023 St. Louis Regional Center Primary? |
| <input type="checkbox"/> 013 Hannibal Regional Center Primary? | <input type="checkbox"/> 029 Central Missouri Regional Center Primary? |
| <input type="checkbox"/> 014 Kansas City Regional Center Primary? | <input type="checkbox"/> 007 Bellefontaine Habilitation Center Primary? |
| <input type="checkbox"/> 015 Joplin Regional Center Primary? | <input type="checkbox"/> 025 Developmental Disabilities Treatment Center Primary? |
| <input type="checkbox"/> 016 Springfield Regional Center Primary? | <input type="checkbox"/> 024 Nevada Habilitation Center Primary? |
| <input type="checkbox"/> 017 Rolla Regional Center Primary? | <input type="checkbox"/> 633 SEMO Residential Services Primary? |
| <input type="checkbox"/> 018 Poplar Bluff Regional Center Primary? | <input type="checkbox"/> 022 Higginsville Habilitation Center Primary? |
| | <input type="checkbox"/> 006 Marshall Habilitation Center Primary? |

Placement Type Requested (All That Apply)

- Family Living Arrangement (FLA)
- Group Home
- Habilitation Center – Privately Operated
- Habilitation Center – State Operated
- Individual Supported Living (ISL)
- Intermediate Care Facility/MR (ICF/MR)
- Natural Home
- Nursing Home
- Residential Care Facility (RCF)
- Skilled Nursing Facility (SNF)
- Supported Living Arrangement (SLA)

Placement History (Fill in Multiple)

	# of Placements (ie 5 times)	In this Time Period (ie 5 years)
Department of Corrections		
Family Living Arrangement (FLA)		
Foster Home		
Group Home		
Habilitation Center – Privately Operated		
Habilitation Center – State Operated		
Hospital - Psychiatric		
Individual Supported Living (ISL)		
Intermediate Care Facility/MR (ICF/MR)		
Natural Home		
Nursing Home		
Residential Care Facility (RCF)		
Skilled Nursing Facility (SNF)		
Supported Living Arrangement (SLA)		
Treatment Center (Public)		
Treatment Center (Private)		

Preferred Counties, Regions, Cities (All That Apply)

Will OR Will NOT Consider other options than these listed...

Counties: _____

Cities: _____

Regions: _____

Requestor (All That Apply)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Consumer | <input type="checkbox"/> Habilitation Team |
| <input type="checkbox"/> Court Order | <input type="checkbox"/> Olmstead Decision |
| <input type="checkbox"/> Forensic | <input type="checkbox"/> Professional Team |
| <input type="checkbox"/> Guardian | |

About the Transition Continued...

Provider Exceptions (All That Apply)

Do NOT Show to these providers: _____

Show ONLY to these providers: _____

* NOTE: Providers suspended in ConsRef do not need to be listed here unless the intent is to exclude this provider when/if suspension is lifted.

Financial Resources (All That Apply)

Currently Medicaid Eligible? Yes No

Category	Financial Resource	Monthly Amount	Comments
Income	Assistance from family/friends		
Income	Bank & Savings Accounts		
Income	Employment		
Income	Railroad Benefits		
Income	Social Security		
Income	Supplemental Security Income		
Income	Trust Funds/Annuities		
Income	Veterans Benefits		
Insurance	Burial Plan		
Insurance	Life Insurance		
Personal Property	Burial Lot		
Personal Property	Household Furnishings		
Public Assistance	Blind Pension		
Public Assistance	Food Stamps		
Public Assistance	Supplemental Aid to the Blind		
Public Assistance	TANF		

Legal Resources (All That Apply)

I have checked the legal guardian information in CIMS (later CIMOR). It is accurate.

	Full Name	Address City, State, Zip	Phone Number
Conservatorship			Home: Cell: Work:
Power of Attorney Health			Home: Cell: Work:
Power of Attorney Legal			Home: Cell: Work:
Social Security Benefit Payee			Home: Cell: Work:
Other (Describe Relationship ~ guardian not required here)			Home: Cell: Work:

DMH Contacts (All That Apply)

Name: DMH Facility: Show to Providers: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone 1: Work Phone 2: Cell Phone: Fax: E-Mail: Other:	<input type="checkbox"/> HC Placement Coordinator <input type="checkbox"/> HC Program Supervisor <input type="checkbox"/> HC Social Worker <input type="checkbox"/> RC Placement Coordinator <input type="checkbox"/> RC Transition Coordinator <input type="checkbox"/> RC Transition Supervisor <input type="checkbox"/>
Name: DMH Facility: Show to Providers: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone 1: Work Phone 2: Cell Phone: Fax: E-Mail: Other:	<input type="checkbox"/> HC Placement Coordinator <input type="checkbox"/> HC Program Supervisor <input type="checkbox"/> HC Social Worker <input type="checkbox"/> RC Placement Coordinator <input type="checkbox"/> RC Transition Coordinator <input type="checkbox"/> RC Transition Supervisor <input type="checkbox"/>

About the Consumer

Day Activities (All That Apply)

Day Activity	Full Time	Part Time	Category
<input type="checkbox"/> Day Habilitation	<input type="checkbox"/>	<input type="checkbox"/>	Day Habilitation
<input type="checkbox"/> Vocational Training	<input type="checkbox"/>	<input type="checkbox"/>	Education
<input type="checkbox"/> Classroom Setting	<input type="checkbox"/>	<input type="checkbox"/>	Education
<input type="checkbox"/> Pre-Vocational Training	<input type="checkbox"/>	<input type="checkbox"/>	Education
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Therapy
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Therapy
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Therapy
<input type="checkbox"/> Horticulture Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Therapy
<input type="checkbox"/> Competitive Employment	<input type="checkbox"/>	<input type="checkbox"/>	Work
<input type="checkbox"/> Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	Work
<input type="checkbox"/> Sheltered Employment	<input type="checkbox"/>	<input type="checkbox"/>	Work
<input type="checkbox"/> Volunteer	<input type="checkbox"/>	<input type="checkbox"/>	Work

Daily Living Needs (All That Apply)

	Needs Assistance	Fully Dependent
Bathing	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>

Medical Support Needs (All That Apply)

- | | |
|---|---|
| <input type="checkbox"/> Allergy(s) | <input type="checkbox"/> Mobility - Walker/Cane |
| <input type="checkbox"/> Ambulatory | <input type="checkbox"/> Mobility - Walks independently |
| <input type="checkbox"/> Bowel Care | <input type="checkbox"/> Mobility - Walks unaided with difficulty |
| <input type="checkbox"/> Braces | <input type="checkbox"/> Mobility - Walks with supportive devices |
| <input type="checkbox"/> Catheterization | <input type="checkbox"/> Oxygen therapy |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Skin Breakdown |
| <input type="checkbox"/> Diabetes, Insulin Dependent | <input type="checkbox"/> Special Diet Preparation |
| <input type="checkbox"/> Diabetes, Non-Insulin Dependent | <input type="checkbox"/> Speech - Communicates using assisted devices |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Speech - Communicates using gestures or eye pointing |
| <input type="checkbox"/> Handicap accessible environment | <input type="checkbox"/> Speech - Communicates using sign language |
| <input type="checkbox"/> Handicap accessible transportation | <input type="checkbox"/> Speech - Difficult to understand |
| <input type="checkbox"/> Hearing - Deaf | <input type="checkbox"/> Speech - No functional communication |
| <input type="checkbox"/> Hearing - Hearing Aids | <input type="checkbox"/> Speech - Normal |
| <input type="checkbox"/> Hearing - Normal | <input type="checkbox"/> Suctioning |
| <input type="checkbox"/> Hearing - Partial hearing loss | <input type="checkbox"/> Therapeutic Positioning |
| <input type="checkbox"/> Hearing - Unknown or undetermined hearing capabilities | <input type="checkbox"/> Tracheotomy |
| <input type="checkbox"/> Illnesses that interfere with daily routine | <input type="checkbox"/> Tube Feeding |
| <input type="checkbox"/> Illnesses that require medical attention | <input type="checkbox"/> Uncontrolled seizures |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Ventilator |
| <input type="checkbox"/> Mobility - Crawls | <input type="checkbox"/> Vision - Blind |
| <input type="checkbox"/> Mobility - Electric wheelchair independently | <input type="checkbox"/> Vision - Impaired but corrected with glasses |
| <input type="checkbox"/> Mobility - Electric wheelchair with transfer assist | <input type="checkbox"/> Vision - Impaired vision |
| <input type="checkbox"/> Mobility - Lift | <input type="checkbox"/> Vision - No functional vision |
| <input type="checkbox"/> Mobility - Manual wheelchair with assistance | <input type="checkbox"/> Vision - Normal |
| <input type="checkbox"/> Mobility - Manual wheelchair with transfer assistance | <input type="checkbox"/> Vision - Travel vision but legally blind |
| <input type="checkbox"/> Mobility - Manual wheelchair without assistance | <input type="checkbox"/> Vision - Unknown or undetermined visual ability |
| <input type="checkbox"/> Mobility - Requires total assistance with mobility | <input type="checkbox"/> Wears depends |

Staff Support Needs (All That Apply)

- | | |
|--|--|
| <input type="checkbox"/> Sign Language | <input type="checkbox"/> Max Time Alone – Less Than 1 Hour |
| <input type="checkbox"/> 24 Hour | <input type="checkbox"/> Max Time Alone – 10+ Hours |
| <input type="checkbox"/> Moderate Supervision | <input type="checkbox"/> Unable to Evacuate Without Assistance |
| <input type="checkbox"/> Line of Sight | <input type="checkbox"/> Max Time Alone – 1-3 Hours |
| <input type="checkbox"/> Awake, Overnight Staff | <input type="checkbox"/> Max Time Alone – 3-10 Hours |
| <input type="checkbox"/> Constant Supervision | <input type="checkbox"/> 1:1 Staffing |
| <input type="checkbox"/> Requires RN/LPN oversight on all shifts | <input type="checkbox"/> More than 1:1 Staffing |
| <input type="checkbox"/> Max Time Alone – Less Than 15 Minutes | |

About the Consumer Continued...

Behavioral Issues (All That Apply)

Monitoring Needed

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Protection Needed

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- Chemical Abuse
- Dishonesty
- Elopement
- Physical Aggression
- PICA
- Property Destruction
- Self-Abuse
- Sexuality
- Sexuality (Predator - Preference Female)
- Sexuality (Predator - Preference Male)
- Sexuality (Predator - Children)
- Social Interactions
- Survival Skills
- Verbal Aggression
- Stealing
- Fire Setting

Diagnosis

- I have checked the Diagnosis in the computer system. Include them all on the provider referral.
- OR
- Exclude (write in the diagnosis code): _____
- Exclude (write in the diagnosis code): _____
- Exclude (write in the diagnosis code): _____

Family Involvement (Check Only One)

- Frequent
- Infrequent
- None

Intellectual Skills (All That Apply)

Moderate

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-

Serious

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-
-

- Coping Skills: Does not handle everyday stress
- Coping Skills: Dislikes disruptions in environment
- Judgment Impaired: Easily Taken Advantage Of
- Judgment Impaired: Inability to Advocate for Self

Moderate

-
-
-
-

Serious

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-

- Judgment Impaired: Rational Decisions Health
- Judgment Impaired: Rational Decisions Financial
- Judgment Impaired: Rational Decisions Safety
- Recognize Reality: Paranoia or Delusional Behavior

About the Consumer Continued...**Other Narratives/Comments** (All That Apply)

Narrative Categories	Narrative Types	Comments
Day Activities	Day Hab Provider Preference	
Day Activities	Education Vocational Training	
Day Activities	School Age -District/Classroom Preference	
Financial Information	Household Furnishings	
Financial Information	Other Income	
Financial Information	Outstanding Debt	
Legal Resources	Legal Guardian	
Legal Resources	Payee	
Location Preference	Location Preferences (i.e. anything unusual not handled in preferred regions/cities/counties tabs)	
Medical	Current Medical Condition/Treatment	
Medical	Current Medications	
Medical	Current Physician and Specialists	
Medical	Medical Supplies and Equipment	
Medical	Special Training (i.e. insulin, seizures, breathing, body fluids, speech, range of motion)	
Personal Change Inventory	Life Style Changes - Anticipated Emotional (list anticipated supports/ interventions needed for transition)	
Personal Change Inventory	Life Style Changes - Anticipated Physical (list anticipated supports/ interventions needed for transition)	
Personal Change Inventory	Life Style Changes - History Emotional (List the change and impact on emotional health - successful and unsuccessful supports/interventions)	
Personal Change Inventory	Life Style Changes - History Physical (List the change and impact on emotional health - successful and unsuccessful supports/interventions)	
Personal Change Inventory	Living Environment - Health/Safety Issues (i.e environmental safeguards, fire/disaster drills, etc.)	
Other	Significant Comments	

Activity Tracking (Part 1)

For these types of transitions, fill in a date or text as indicated by the "X" below:

- Habilitation Center Community Residence to Community (Also Complete Part 2)
- Habilitation Center to Community (Also Complete Part 2)
- Nursing Home to Community (Also Complete Part 2)

Activity Definition	Date	Text
Guardian Consent To Explore Options (Olmstead)	X	
Planning Meeting	X	
Written HIPAA Consent (if applicable)	X	
Health Inventory Completed	X	
Regional Center Activated Case	X	
Health Inventory Obtained by RC	X	
MoAide Invited to Speak with Consumer	X	

Activity Tracking (Part 2)

For these types of transitions, fill in a date or text as indicated by the "X" below:

- Community to Habilitation Center (Long Term)
- Community to Habilitation Center (Short Term)
- DMH Placement to Natural Home
- Habilitation Center Community Residence to Community
- Habilitation Center to Community
- Habilitation Center to DMH CPS
- Habilitation Center to Habilitation Center
- Move within Community (Provider Change)
- Natural Home to Community
- Nursing Home to Community

Activity	Date	Text
Written HIPAA Consent (if applicable)	X	
Placement Type Selected		X
Referral Packet (Full) Received From Service Coordinator	X	
Referral Packet (Full) Sent to Provider	X	X
Transition Meeting	X	
Closure Meeting	X	
Targeted Move In Date	X	
Actual Move-In Date	X	
30 Day Follow Up Completed	X	

Consumer Residential Referral Form Instructions

*** = Required (Note: Recommend that ALL items be filled out completely)**

***Consumer Identification:** Provide the consumer name, local client ID (or statewide ID) and the date this referral is being initiated.

***Transition Type:** Check one box only to indicate the type of transition about to take place. This field is mandatory and critical to the ConsRef system. Depending on what is selected here, the provider community may or may not be able to see this referral. This selection also generates the types of activity that are required to be tracked in ConsRef. If this transition is a result of Olmstead, mark yes. Otherwise, mark no.

Current Residence: Check a box for the consumer's current type of residence.

***To DMH Facility (Check All That Apply and Circle for Primary):** Represents the DMH facility(s) working to place this consumer. Check all that apply. You may optionally indicate the primary DMH facility by circling that "Primary?" option. This field is mandatory and critical to the ConsRef system. Activity tracking is generated for each facility checked here.

Placement Type Requested: Check all that apply for the type of placement a consumer is requesting.

Placement History: Indicate the number of times a person has been placed in each category and indicate the time period to which you are referring. This provides a greater understanding of successful or unsuccessful placements.

Preferred Counties, Regions, Cities: If the consumer prefers certain counties, regions, or cities, please indicate here.

Requestor: Check all that apply to indicate who requested this transition.

Provider Exceptions: Providers who are on a plan of correction will be "suspended" in the system. These providers do not need to be noted here. If the family/consumer has a preference as to what provider(s) to use or not to use, indicate that here.

Financial Resources: Is the client currently Medicaid eligible? Additionally, if there is any type of financial resource that is important to describe, place it here. In the comment section, DO NOT include Protected Health Information (PHI). The provider views these comments but all other PHI is protected from their view.

Legal Resources: List all that apply. Legal resources are not initially released to the provider community, but useful for internal purposes. The referral will indicate that a legal resource exists (yes or no).

DMH Contacts: DMH Contacts may or may not be listed on the consumer referral. These may be used internally or shown to the providers as they view the referral. Tip: Once a name and contact information is entered into the system, it is saved in a master file and can be easily retrieved. If the name is already in the master file, provide only the name and whether or not to show it to providers unless the other information has changed.

Day Activities: Check all day activities that apply and indicate whether that activity is part or full time.

Daily Living Needs: Check all daily living needs that apply and indicate whether that need requires assistance or full dependent. If the need listed is not an issue, do not check anything.

Medical Support Needs: Check all medical support needs that apply.

Staff Support Needs: Check all staff support needs that apply.

Behavioral Issues: Check all behavioral issues that apply and indicate whether monitoring or protection is needed.

***Diagnosis:** Diagnosis is automatically pulled from MRDDIS and CIMOR in the future. Therefore, it is not necessary to list each diagnosis here. Instead, review MRDDIS (later CIMOR) for two things: 1) Make sure the list is accurate and 2) mark on this form any diagnosis that should not be shown to the provider community (rare to exclude one).

Family Involvement: Check one to indicate if the family is involved with the consumer's life.

Intellectual Skills: Check all that apply and indicate whether the skill is moderate or serious. If there is no problem with the skill, leave it unchecked.

Other Narratives/Comments: Use this section to describe anything that will bring further clarity to this referral. In the comment section, DO NOT include Protected Health Information (PHI). The provider views these comments but all other PHI is protected from their view.