

Client Referral Summary

SOURCE OF INFORMATION (CHECK ALL THAT APPLY)

- ☐ Interview client
 ☐ Other:
- ☐ Interview guardian / family
- ☐ Current PCSP
- ☐ Current IISP

CLIENT NAME (PREFERRED NAME AND PRONOUNS)	ADSA ID	CLIENT DOB	CURRENT CONSENT VALID UNTIL:
	DATE	DATE UPDATED	INCLUDED <input type="checkbox"/> YES <input type="checkbox"/> NO

Insert photo and/or any additional information the client / legal representative would like to include here if available:

The client referral summary is intended to present a concise person-centered summary of the supports needed for a person to be successful in the community. This is the first impression a potential provider will receive about the client. Focus on current information (within the last 12 months), what has been successful, what has been a challenge in the past, important to know about the setting the client is coming from and going to. If information older than a year is included document the date of occurrence.

1. Person Centered Description (focus on representative the client how they would present themselves)

What are the client's likes, dislikes, strengths?

How is the client connected to their community?

If yes is marked, comment is mandatory.

Housemate or staff preference? ☐ Yes ☐ No

If yes, describe:

Accessibility or environmental adaptations needed? ☐ Yes ☐ No

If yes, describe (include detail of what type of environment they need to be successful, i.e. no stairs, accessible bathroom, etc.):

Preference of pet in home? ☐ Yes ☐ No

Describe:

Does the client smoke? ☐ Yes ☐ No

Describe:

Any other preference or barrier, deal breakers (i.e., provider who knows ASL):

Marital Status: ☐ Single ☐ Married

Important relationships to you (partners, children that live with you, other children, etc.):

Allergies, sensitivities, or special diets (scent free, etc.):

Anything else important to the client and/or people close to them? ☐ Yes ☐ No

Describe (Include what would make the provider a good fit, quiet home, rural vs. in town, support beliefs, etc.):

2. Referral Information

Residential level (if unknown, please write TBD):

Moving from:

Who is currently supporting the client:

Geographic preferences? Where does the client want to live (cities / counties):

Attach list of selected providers.

Is the client on or being considered for community protection waiver? ☐ Yes ☐ No

3. Supports Requested (summarize the information a minimum of three or four sentences for each section. Summarize the various sections of the CARE assessment.)

To be successful in the community what supports does the client need with daily living skills (including any adaptive equipment used, include supports needed for ADLs and IADLs):

To be successful in the community what supports does the client need with behavioral supports (will the client need a Positive Behavior Support Plan, Cross System Crisis Plan, other plans? Are all of the supports in place in their current setting able to be replicated in the community setting? What does safe community living look like? Include needed restrictions or special staffing requirements, current behavioral health support):

To be successful in the community what supports does the client need with community activities (what supports around, community outings, grocery shopping, riding in car or bus, using money, etc.):

To be successful in the community what supports does the client need with medication assistance or nursing services needed (nursing, skin care, nurse delegation, tube feeding, lab work, injections, specialized medical care, or monitoring of chronic conditions, etc.):

To be successful in the community what additional services are needed (employment interpreter / communication supports, therapies, specialized transportation):

Specify known assessed risks or any significant health or safety concerns (falls, stairs, lack of community awareness, unable to use phone to call for help, seizures, etc. If client is currently in SL, they will have a risk summary as part of their IISP where this can be found.):

Name and contact of legal representative, if applicable. (Include other involved parties as requested by the client. Indicate level of involvement if there is a legal representative for the client.):

CASE MANAGER'S NAME	TELEPHONE NUMBER	DATE	<input type="checkbox"/> Forward to Supervisor
4. Provider Response (must complete after 03/01/2021)			
<p>If interested in exploring further:</p> <p><input type="checkbox"/> I would like to review the full packet for this client.</p> <p><input type="checkbox"/> I would like to discuss additional options with the resource team.</p> <p>If declined:</p> <p>I decline this referral for the following reason (select one or more):</p> <p><input type="checkbox"/> Agency does not wish to add an additional home at this time.</p> <p><input type="checkbox"/> Unable to recruit and retain enough staff to start new home within timeline desired for start of services.</p> <p><input type="checkbox"/> Unable to fill current vacant positions, vacancy rate is _____.</p> <p><input type="checkbox"/> Do not have management or program staff or DSP expertise to meet client unique needs.</p> <p><input type="checkbox"/> Housemate match is not compatible.</p> <p><input type="checkbox"/> Lack the infrastructure to add clients (program managers, trainers, human resource support).</p> <p><input type="checkbox"/> Client or guardian expectations cannot be met.</p> <p><input type="checkbox"/> Other (please explain):</p> <p>I have <input type="checkbox"/> returned or <input type="checkbox"/> destroyed the referral summary per my contract.</p>			
PROVIDER'S NAME	TELEPHONE NUMBER	DATE	