Referral Information Form

Please save the form to your computer **BEFORE** you start.

Rename the pdf by including **the person's FIRST INITIAL and LAST NAME that you are referring** in the file name (For example: BehaviorWizards-ReferralForm-MJones.pdf).

DATE INFORMATION SENT:

Name:

DOB: Sex: M ☐ F ☐ Race: SSN:

PMI#: Medicare#: Other Insurance:

Serving County: Financial County:

Legal Status/Representative:

CASE MANAGER:

Name: Address:

City: State: Zip:

Telephone: Fax: Email:

LEGAL REPRESENTATIVE:

Name: Address:

Relationship: City: State: Zip:

Telephone: Fax: Email:

RESIDENCE:

Name: Address:

Contact Person: City: State: Zip:

Telephone: Fax: Email:

Type of Program (Waiver/ICF-MR/Other):

DAY PROGRAM/SCHOOL:

Name: Address:

Contact Person: City: State: Zip:

Telephone: Fax: Email:

Type of Program (Waiver/ICF-MR/Other):

PRIMARY CORRESPONDENT/FAMILY CONTACT:

Name: Address:

Relationship: City: State: Zip:

Telephone: Fax: Email:

MEDICAL CONTACT:

Name: Address:

City: State: Zip:

Telephone: Fax: Email:

Was this client referred by the Physician: YES ☐ NO ☐

Diagnosis (Include DSM V Code):

Medications:

PRESENTING PROBLEM & SERVICES UTILIZED PRIOR TO BEHAVIOR WIZARDS REQUEST:

Services Requested: Behavior Wizards (as the license holder) must provide and submit a summary of the services as authorized by the county case manager. The summary shall be provided to the case manager within 30 days of service termination. Check which services the case manager is requesting. If none are specified, A–C will be provided.

☐ **A** Assessment to determine the precipitating factors contributing to the crisis, including recommendations for medical assessments as appropriate (document in medical records if medical assessment is necessary or not).

☐ **B** Development of a provider intervention plan in coordination with the service planning team.

☐ **C** Consultation and staff training to the provider(s) and/or caregiver(s) as necessary to assure successful implementation of the recipient specific intervention plan.

☐ **D** Development and implementation of a transition plan to aid the recipient in returning home if out-of-home crisis respite was provided.

☐ **E** Ongoing technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the recipient.

☐ **F** Recommendations for revisions to the 24-hour plan of care for the consumer to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the recipient in the community.

ADDITIONAL COMMENTS/REQUESTS: (Provide any additional information of use)

EXPECTED OUTCOME: (Case manager goals for services)

Is the client at risk of losing the current placement? Yes ☐ No ☐

Person making the referral:

Relationship to the client:

How quickly is Behavior Wizards intervention needed?
- ☐ within 48 hours
- ☐ within 72 hours
- ☐ within one week
- ☐ within two weeks

Authorization of Initial Units (Completed by case manager)

(The start date will be the date of initial meeting when arranged by Behavior Wizards staff – funding source and units approved needs to be completed by case manager prior to the Initial Meeting.)

Funding Source Used	Cost (Per Unit)	Billing Code	Unit Length	Waiver Type	Waiver Title	Units Approved	Start Date
☐	$28.50	T1005	15 Minutes	DD	Crisis Respite		
☐	$28.50	S5110	15 Minutes	CADI,CAC or TBI	Crisis Respite		
☐	$114.00	T2013	60 Minutes	DD	Specialist Services		
☐	$28.50	Contracted Service	15 Minutes	FSG* or CDCS	Behavior Consultation		

*FSG = Family Support Grant (By County Agreement)

SERVICE AUTHORIZATION

WAIVER – Case manager must screen the client for crisis-respite services on the screening doc and authorize crisis-respite services on the service agreement. Billed directly to MMIS II using crisis-respite provider number. Update the ISP to reflect the need for crisis respite services.

ICF-MR-PROVIDER is responsible for payment and billed directly. Provider may obtain authorization for crisis-respite services through 186. Shared service contract must be initiated and signed.

SPECIAL SERVICES CONTRACT – This includes use of Family Support Grant or other non-waiver funding sources.

Attach copies of the following documents:

Coordinated Service Support Plan (CSSP)

Consent for Release of Information

Individual Abuse Prevention Plan (IAPP)

Current Psychological Assessment

Current Individualized Education Plan (if consumer is attending school).

Email to: **jon.freer@behaviorwizards.com**

You may also print and FAX or mail a printed copy of your application to:

Behavior Wizards
2131 Troop Drive
Sartell, MN 56377

Phone: **320-230-2708** or **218-839-9135**

FAX: **320-230-3145**