maximus

Illinois Referral Form
Supportive Living Program (SLP)

Part I: Demographics

First Name	Middle Initial	Last Name	Suffix

Mailing Address

City	State	Zip	County	Gender
				☐ Male ☐ Female ☐ Other: _____

Phone Number

Date of Birth

Unique Identifier
☐ Social Security Number ☐ Passport ID ☐ Temporary Resident ID
☐ Driver's License/State ID ☐ Medicaid ID ☐ AssessmentPro IID
☐ The individual doesn't have any of these IDs Identifier Number: _____

Marital Status
☐ Married ☐ Single ☐ Widowed ☐ Divorced

Payment Method
☐ Medicaid ☐ Medicare ☐ Self-Pay ☐ Private Insurance
☐ Medicaid/Long-Term Care Pending
Medicaid ID: _____ Medicare ID: _____

Race
☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ Hispanic/Latino/Spanish
☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other (specify): _____

Current Location
☐ Community Setting ☐ Critical Access Hospital
☐ Hospice Care Facility ☐ Medical Facility Medical Unit
☐ Medical Facility ER/ED ☐ Medical Facility Psych Unit
☐ Psychiatric Facility ☐ Nursing Facility
☐ Shelter ☐ PACE Facility
☐ Home ☐ SLP
☐ SMHRF ☐ Other (specify): _____

Current Location Address

Admission Date

Current Location Phone Number

What has been his/her typical living situation over the past year?
☐ Home alone ☐ Home w/natural supports ☐ Home w/paid supports ☐ Assisted living
☐ Nursing facility ☐ Shelter ☐ Group home ☐ Psychiatric facility
☐ Correctional Facility ☐ ICF/IID ☐ SLP ☐ SMHRF
☐ Homelessness ☐ Other (specify): _____

Prospective SLP Name

Prospective SLP Address

Part II: Reason for Screening
☐ Preadmission Screen: Initial Screening for SLP setting participation
☐ Transfer: Nursing Facility to SLP Setting
☐ Transfer: SLP setting to SLP setting
☐ Expiration of prior SLP screen or assessment
☐ Conversion: Private pay SLP participant converting to Medicaid

Part III: Reasonable Basis To Suspect A Developmental Disability

The individual has been formally diagnosed with Intellectual Disability (ID), Developmental Disability (DD) such as Cerebral Palsy, Epilepsy, Autism, or any other condition (other than mental illness) found to be closely related to ID/DD because this condition results in impairments of general intellectual functioning or adaptive behavior similar to that of individuals with Intellectual Disability and requires services similar to those required for such individuals ***AND*** the condition was manifested prior to the age of 22	☐ No ☐ Yes. Indicate applicable condition: ☐ Intellectual Disability (ID) ☐ Developmental Disability (DD) ☐ Other (specify):
The individual experienced seizures prior to the age of 22.	☐ No ☐ Yes
The individual has received special education and/or day program services.	☐ No ☐ Yes
The individual remained at home with family and did not go to school or work.	☐ No ☐ Yes

Last Name_____ First Name_____ DOB_____

There are other indicators of intellectual or developmental disability.	☐ No ☐ Yes. Specify other indicator(s):

Part IV: Reasonable Basis To Suspect A Mental Illness

The individual has been formally diagnosed with a mental illness verified by a DSM-IV classification which substantially impairs the person's cognitive, emotional and/or behavioral functioning, excluding organic disorders/dementia, developmental disabilities, and alcohol/substance abuse.	☐ No ☐ Yes
The individual has a history of psychiatric hospitalization.	☐ No ☐ Yes
The individual has a history of outpatient mental health services.	☐ No ☐ Yes
There are other indicators of mental illness.	☐ No ☐ Yes. Specify other indicator(s):

Guardianship & Physician Information

Does the individual have a legal guardian? ☐ No legal guardian. ☐ Yes, information is below:

Legal Guardian Last Name_____ First Name_____ Phone:_____

Street_____ City_____ State_____ Zip_____

Primary Physician's Name: _____ Phone:_____ Fax:_____

Street_____ City_____ State_____ Zip_____

Referral Source Signature

I attest that the information submitted herein is true and accurate to the best of my knowledge. I understand that misrepresentation of the individual in the screen is considered Medicaid fraud.

Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax: