# *ICF-IID Referral and Prescreen*

Kansas
Department for Aging and Disability Services

| 1. Consumer Information | | | |
|---|---|---|---|
| Name: | | Birthdate: | |
| Medicaid ID: | | Managed Care Organization: | |
| Care Coordinator: | | Coordinator Contact: | |
| Referral Source: | | Referral Representative: | |

Is the consumer a Kansas resident? ☐ Yes ☐ No

Has a BASIS assessment been completed? ☐ Yes ☐ No Date Completed: _____

Was a request for IDD Crisis submitted? ☐ Yes ☐ No What was the crisis decision? _____

Was a request for Extraordinary Funding (FE) submitted? ☐ Yes ☐ No What was the EF decision? _____

Has an IQ Evaluation been completed? ☐ Yes ☐ No Date Completed:

IQ Score Diagnosis: _____

Does the consumer have a court-appointed legal guardian? ☐ Yes ☐ No

Has the guardian been granted authority by the Court to admit the consumer to an institution? ☐ Yes ☐ No

Who is requesting a referral for admission to an ICF-IID facility? _____

Does the consumer/guardian consent for placement in an institution? ☐ Yes ☐ No

Is this a request for placement in a public or private institution? ☐ Public ☐ Private

Where is the consumer transitioning from?
☐ Community Setting
☐ Jail/Correctional Facility
☐ Out-of-state
☐ Other: _____

Why are community supports and services not able to meet the needs of the consumer?

What are the consumer's barriers to successful community living?



KDADS/CSP/ICF-IID Referral and Prescreen Form
Developed: 1/21/15
Revised: 8/1/15

## 2. Community Services Explored

Provide a detailed description of the community services explored by the consumer. The description should include, but is not limited to, the following:

a. Service Type (i.e., HCBS)
b. Name of each provider/organization explored
c. Method of exploration
d. Reason service/provider is unable to provide services to the consumer

**Response:**

a.

b.

c.

d.

## 3. Community Services Exhausted

Provide a detailed description of the community services exhausted by the consumer. The description should include, but is not limited to, the following:

e. Service Type
f. Duration of service utilization
g. Name of each service provider/organization exhausted
h. Reason service is not sufficient to meet the consumer's needs

**Response:**

e.

f.

g.

h.

## 4. Private ICF-IID

Provide a detailed description of the private ICF-IID explored or exhausted by the consumer. The description should include, but is not limited to, the following:

i. Name of each ICF-IID facility/organization explored or exhausted
j. Reason ICF-IID is not sufficient to meet the consumer's needs

**Response:**

i.

j.

***NOTE: Any provider refusal to accept or provide services or MCO denial to authorize services must be documented in writing and submitted with this referral.***

✓ KDADS will not review the referral if the required documents have not been submitted.

**Consumer/Guardian Consent**

As the consumer or guardian, I attest that (*initial by each statement*):

_____The information provided above for the referral and prescreen is accurate to the best of my knowledge.

_____I have reviewed the referral and prescreen form and agree with the contents provided in the document.

_____I permit the submission of the referral and prescreen to the Kansas Department for Aging and Disability Services (KDADS) to review.

Consumer/Guardian Name (print)

Consumer/Guardian Signature Date:

| **Referral Submission** | | | |
|---|---|---|---|
| Name | | Contact (phone/email) | |
| Organization | | Submission Date | |

| KDADS Review | | | |
|---|---|---|---|
| Date Received | | Determination Date | |
| Reviewed by: | | | |
| Determination: | ☐ Proceed with gatekeeping summary<br>☐ Insufficient Documentation | | |