NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

## CERTIFIED RESIDENTIAL OPPORTUNITIES

# RESIDENTIAL REFERRAL

**Instructions:** As indicated in the Protocol for Certified Residential Opportunities (CRO), the service coordinator/referral source should complete this form when referring an individual to the CRO Team for consideration. The CRO Team receives, reviews, and processes all residential referrals then will assign a level of need designation utilizing OPWDD's Statewide Criteria (see below). The CRO Team will notify the service coordinator/referral source of the level assigned, in writing, within 5 business days of receiving the complete referral packet. *Note: incomplete referrals are returned to the service coordinator. Missing information will be identified in the "Referral Incomplete: Additional Information Required" section at bottom of this form.*

**BASIC DEMOGRAPHICS**

| | | |
|---|---|---|
| Individual's Name: _____<br>TABS #: _____<br>ISPM Score: _____ | DOB: _____<br>Gender: _____ | Street Address: _____<br>City: _____<br>State: _____ Zip Code: _____ |
| OPWDD Eligibility Confirmed: ☐ Yes* ☐ No<br>*eligibility letter must be attached | | HCBS Enrollment Pending: ☐ Yes ☐ No<br>Effective Date of HCBS Waiver NOD: _____ |
| Current Living Situation:<br>☐ Family Care – *specify agency:* _____<br>☐ ICF – *specify agency:* _____<br>☐ Supportive Apartment – *specify agency:* _____<br>☐ IRA – *specify agency:* _____<br>☐ Supervised Apt – *specify agency:* _____<br>☐ Other – *specify, including agency:* _____ | | Care Manager Name: _____<br>Care Coordination Organization: _____<br>Phone Number: _____<br>Email Address: _____<br>CM Supervisor Name: _____<br>CM Supervisor Phone Number: _____ |
| Diagnosis (list all): | | Legal Representative Information<br>Name:_____<br>Phone Number:_____<br>Email Address:_____ |

If the individual is over the age of 18 and lives in their own apartment, will they accept a residential opportunity?
☐ Yes ☐ No ☐ Individual is Under 18
If no, please explain:

**INDIVIDUAL NEEDS**

Ambulation/Abilities: _____
Self-preservation (fire)/safety issues: _____
Communication abilities: _____
Self-help abilities/ADLs: _____
Behavioral issues: _____
Risk Management Plan: ☐ Yes ☐ No Behavior Plan: ☐ Yes ☐ No
Specialized medical conditions: _____
Medications: _____
Forensic issues: _____
Current services received: _____

**RESIDENTIAL RECOMMENDATIONS**

Level of supervision at residence recommended including rationale: _____
Other pertinent information to be considered: _____
County/city preferred: _____
Other counties/cities individual would consider: _____
If this an emergency/crisis need for placement in a certified site, please explain:_____

**TO BE COMPLETED BY INDIVIDUAL AND/OR LEGAL GUARDIAN**

I consent (agree) to have this request for a residential placement in an OPWDD supported home made on my behalf. I understand that my medical and/or clinical information will be shared with agencies that provide residential services. I understand that I have the right to withdraw my request for placement at any time.

_____ Date: _____
Name of Individual/Family/Advocate granting authorization

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**Submit form to:**

DDRO Certified Residential Opportunities Team

**TO BE COMPLETED BY INDIVIDUAL SUBMITTING THIS REFERRAL**

By entering my name below, I confirm that I've explained the residential referral process to the above-named individual and/or the family/legal representative and that they understand and consent to sharing personal information that will assist the CRO team in identifying an appropriate residential opportunity for him/her.

_____ Date: _____
Person Reviewing This Information & Obtaining
Consent From the Individual Referred

**OPWDD STATEWIDE CRITERIA**

**EMERGENCY NEED**

- **Homelessness or Immediate Risk to Safety:**
  - Individual has no permanent place to live or is at imminent risk of having no permanent place to live.
  - Individual is at imminent risk to health and safety.
- **Individuals Living with Family/Caregivers**
  - Individual whose family/caregiver has an emergency situation where the primary caregiver is incapacitated, for example due to long term illness and/or permanent injury and there is no other available caregiver.
- **Individuals Living in Other Settings**
  - Individual is ready for discharge from a hospital or psychiatric facility; ready for release from incarceration; in a temporary setting such as a shelter, hotel, or hospital emergency department.

**SUBSTANTIAL NEED**

- **Individuals Living With Family/Caregivers**
  - Individual has increasing risk of having no permanent place to live. This includes an individual whose family or other caregivers are becoming increasingly unable to continue to provide care to manage the individual's needs, including behavioral needs.
- Individual is at increasing risk to their health and safety, or presents an increasing risk to the safety of self or others.
- **Individuals Living In Other Settings**
  - Individual otherwise presents a substantial need for residential placement because they are: transitioning from a residential school or Children's Residential Program (CRP); residing in a developmental center and ready to move to the community; or residing in a skilled nursing facility and ready to move to the community.

**CURRENT NEED**

- Individual has a need for residential placement, has requested and is ready to actively seek a residential opportunity, but the need is not an emergency nor substantial as defined above.

**REFERRAL INCOMPLETE: ADDITIONAL INFORMATION REQUIRED**

☐ **REFERRAL INCOMPLETE**

**Instructions for CRO team**: when referral is incomplete, check box and enter information below which identifies what items are missing, and what additional information is required to complete the referral.

**Instructions for service coordinator**: if the CRO team has determined this referral to be incomplete, please submit the requested information below within 5 business days. Resubmission must include this form and documentation indicated below.

***Information below to be completed by the CRO Team***

Date Referral Received: _____ Date Reviewed: _____ CRO staff:_____
Referral incomplete, returned to service coordinator: Date:_____
Reason: _____
Additional Information Required: _____

Date Referral Received: _____ Date Reviewed: _____ CRO staff:_____
Referral incomplete, returned to service coordinator: Date:_____
Reason: _____
Additional Information Required: _____

Date Referral Received: _____ Date Reviewed: _____ CRO staff:_____
Referral incomplete, returned to service coordinator: Date:_____
Reason: _____
Additional Information Required: _____

**LEVEL OF NEED ASSIGNMENT**
**--- TO BE COMPLETED BY CRO TEAM ---**

Instructions for CRO staff: once complete referral received/reviewed and level of need assigned, complete the Notification of Level of Need Memo and send to SC/referral source.

Date Complete Referral Received: _____ Date Reviewed: _____

Level of Need Assigned: _____ Date:_____

Rationale (Based on State-wide Criteria): _____

CRO staff approving need level:_____ Date: _____