IDD Services Referral Form

Referral Guidelines

- To request service(s), please complete this form and return with supporting documents attached to Deanne Mullins, Senior Clinical Director. You can request a secure email link at dmullins@mycri.org, fax to 703-842-2341, or mail to 14160 Newbrook Drive, Chantilly, VA 20151.

- If you have questions regarding types and availability of services, please contact DeAnne Mullins at (703) 842-2356 or at dmullins@mycri.org.

- Referrals will be reviewed and you will receive contact regarding next steps within 3 business days. Thank you for your interest.

Please attach the following documentation if available:

- **Current Individual Service Plan**
- **Psychological assessment**
- **Psychiatric assessment**
- **Behavior plan**
- **Medical/nursing care plan**
- **SIS assessment**
- **VIDES**
- **Medication Administration Record**
- **List of Physicians/Specialists**
- **RAT**

For referrals of current group home residents, please provide the following documentation:

- **Most recently quarterly report**
- **Any medical or behavioral consultation reports within the last 6 months**
- **Prior medical protocols within the last 6 months**

Individual information

Name: Preferred Pronouns:

Street address:

City: State: Zip:

Current provider if applicable:

Home phone: Cell phone:

Email:

DOB:

Race/Ethinicity:

Social Security #:

Medicaid #:

Emergency contact: Phone:

Relationship:

Court appointed guardian:

- Yes Name: Phone:
- No

Referral Source

Name: Phone:

Agency or relationship:

Referral type

Service requested (Please check all that apply):

- Congregate residential
- Supported living
- In home supports
- Day program
- Community Coaching
- Community Engagement
- Intermediate Care Facility
- Therapeutic consult (Behavioral)
- Skilled nursing

Tier: ______

SIS Score: ____

Type of Waiver: _______________________

Please describe the reason why services are being sought, and current services received if any.

Insurance/Financial information

Please check all that apply:

- Medicaid – Eligibility Worker:_____________________ Phone:____________________
- Medicare
- Private health insurance
- Medicaid Waiver – Community Living
- Medicaid Waiver – Family and Individual Services
- Medicaid Waiver – Building Independence
- SSDI/SSI: $_________________
- Pension or other entitlement: $______________
- Other funding for service: $________________

Supporting Documentation

Medical Diagnosis:

Psychiatric Diagnosis:

For CRI Use Only

Referral Date	Disposition	Reason	Outcome