RESIDENTIAL REFERRAL FORM
INSTRUCTIONS

This form is used to officially refer an individual for placement in a DDS-funded residential program and initiates the 90-day vacancy funding timeline. The form must be completed in full and submitted with the required documentation listed in the Referral Packet Checklist.

HEADER

- **FY:** Current Fiscal Year

SECTION 1: Referral and Contact Information

- **Name of Individual**: Full legal name of the person being referred.
- **Second Referral Date:** This is only used if a second referral is sent to the same site due to a declination by the provider.
- **Referring Area Office / Region**: Name of the DDS Area Office or ABI Region submitting the referral.
- **Area Office / Region Contact**: Staff contact responsible for managing the referral.
- **Provider Agency**: Name of the provider agency being referred to.
- **Residential Site Address(es)**: Address(es) of the residential site(s) being considered.
- **Date of First Referral:** Record the date the form was *first* sent to this provider for this vacancy; this date starts the 90-day funding clock and never changes. If a second referral is later issued, keep this original date here and enter the second-referral date in the "Second Referral Date" line at the top.
- **Date Decision Due**: 30 calendar days from the Date of First Referral—by which the provider must accept or decline.
- **Date Vacancy Must Be Filled**: 90 calendar days from the Date of First Referral.

SECTION 2: Individual and Family Information

- Include the individual's date of birth, age, and current address.
- Provide full contact information for family members or legal guardians, including name, phone, relationship, and email.

SECTION 3: Referral Considerations

- Note any special considerations such as upcoming T22 eligibility, urgent move-in needs, accessibility issues, or identified day programs.

SECTION 4: Provider Decision

- The provider must indicate whether the referral is **Accepted**, **Declined (Agreed)**, **Declined (Not Agreed) or Extension Requested**.
    - If accepted, a move-in must occur within 90 calendar days.
    - If declined but not mutually agreed upon, the provider should expect a second referral; funding will still cease 90 days from the first referral date unless the referral is deemed inappropriate by consensus.
- The provider must sign and date this section.

SECTION 5: Extension Request (If Applicable)

- **Length of Extension**: Indicate how many days beyond the 90-day period are requested.
- **Justification for Extension**: Clearly explain the need for an extension (e.g., hospitalization, delayed discharge).
- **Approvals Required**:
    - Area or ABI Director can approve up to 60 days.
    - Regional Director approval is required for extensions beyond 60 days.
    - Litigation-related holds require Deputy Commissioner approval.

SECTION 6: Residential Referral Packet Checklist

- Use this checklist to include all necessary documents:
    - Emergency Fact Sheet, Guardianship Papers, Medical Info, Behavioral Plans, Assessments, etc.
- Indicate the status of each item:
    - **X** = Included
    - **U** = Unavailable
    - **P** = In Progress
    - **N/A** = Not Applicable
- Send documents securely using encrypted email with "SECURE:" in the subject line.
- Ensure all shared information complies with HIPAA confidentiality standards.

Key Reminders

- The 90-day vacancy funding period starts on the **Date of First Referral** entered on the form.
- Provider must respond within 30 days.
- If no exception applies and the vacancy is not filled within 90 days, DDS funding will cease.
- All decisions, extensions, and communications must be documented in writing and tracked using the ALTR Vacancy Tracking Tool.