THE COMMONNWEALTH OF MASSACHUSETTS

Department of Developmental Services

Residential Referral Form

FY

Name of Individual:	**Second Referral Date:** (only use if first referral declined)
Referring Area Office / Region:	**Area Office / Region Contact:**
Provider Agency:	
Residential Site Address(es):	

Date of First Referral:	**Date Decision Due:**	**Date Vacancy Must Be Filled:**

*NOTE: Provider must review the referral and accept or decline within THIRTY (30) calendar days from the Date of First Referral entered above. Provider must plan for a move date within NINETY (90) calendar days from the Date of First Referral entered above, unless allowable extensions apply. Refer to Vacancy Funding Protocol for details.

INDIVIDUAL INFORMATION

Date of Birth: Age:	Street: City/Town, Zip:

FAMILY/GUARDIAN INFORMATION

Name(s): Telephone:	Relationship: Email:

Referral Considerations (such as T22 birthday, need to move by, accessibility, Day program identified, etc.)

REFERRAL RESPONSE – PROVIDER AGENCY USE ONLY

☐ Accepted ☐ Extension Request ☐ Declined, Agreed ☐ Declined, Not Agreed DATE

Comment:

* Upon acceptance, the provider agrees to a move-in date no later than ninety (90) calendar days from the Date of First Referral entered above, unless an extension to the 90 day period has been approved per Residential Vacancy Funding Protocol.

** If denial is not mutually agreed to, the provider acknowledges that a second referral may be sent, but that funding will cease ninety (90) calendar days from the Date of First Referral if the vacancy is not filled.

*** If requesting an extension to the ninety (90) day timeline, please complete Extension fields below.

Provider Agency Designee Signature	**Date**

EXTENSION REQUEST

Justification for extension	
Length of extension	

EXTENSION APPROVAL

Up to 60 Days: **Area Director/ABI Director or Designee Signature**	**Beyond 60 Days:** **Regional Director Signature**

DDS APPROVAL

Area Director/ABI Director or Designee Signature	**Date Signed**	**Date Enrolled**

THE COMMONWEALTH OF MASSACHUSETTS

Department of Developmental Services

Residential Referral Packet Checklist

Please provide the documents below along with a completed Residential Referral Form.

Name of Individual Referred **D.O.B.**

Current Address **Phone**

Area Office/Region **Service Coordinator**

(If information is included in the packet, please select "X", if unavailable select "U"; if you are in the process of obtaining the information select "P"; if the information is not applicable select N/A.)

	Status
Residential Referral Form	
Profile (optional)	
Release of Information	
Emergency Fact Sheet	
Guardianship papers	
Service plans (ISP, IEP, etc.)	
Current documentation (Assessments, etc.)	
Current providers and contact information	
Medical diagnosis	
Current Medical information (include Health Care Record if available)	
Current Medications	
Current Clinical/Psychiatry information/evaluations	
Behavioral information (treatment plan, behavioral data, etc.)	
Current Dental information	
Vocational/Work evaluations	
Work History	
Risk Plan or Forensic Evaluation ☐ Yes ☐ No If Yes, Reason	

Please scan documents and send them using the secure email process to the provider.

Type "SECURE:" in the subject line.

Please be advised that all of the information contained in this packet is strictly confidential and all parties must follow all HIPAA regulations.