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SPD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***IL24 Program Referral Form***

**Today’s Date:**

**Name:**

**Is this person able to meet virtually if needed? [ ]  Yes [ ]  No – If no, what are the barriers?**

**Check box for County of referral:**

**[ ]  Stearns** **[ ]  Benton** **[ ]  Sherburne** **[ ]  Mille Lacs** **[ ]  Morrison** **[ ]  Meeker** **[ ]  Isanti** **[ ]  Kandiyohi**

**[ ]  Wright** **[ ]  Kanabec** **[ ]  Chisago**

**County of Residence:**

**Check box for services being provided:**

**[ ]  IHS with On-Call/24 Hour Emergency Assistance**

**Type of Referral (Please check which one applies):**

**[ ]  Individualized Home Supports WITH Training**

**[ ]  Individualized Home Supports WITH Family Supports**

**[ ]  HSS, IHS and On-Call/24 Hour Emergency Assistance**

**Type of Referral (Please check which one applies):**

**[ ]  Individualized Home Supports WITH Training**

**[ ]  Individualized Home Supports WITH Family Supports**

 **HSS – there is a separate referral form and process for this service**

**[ ]  HSS and On-Call/24 Hour Emergency Assistance**

 **HSS – there is a separate referral form and process for this service**

**Check Box for which On-Call/24 Hour Tier Plan requesting. Below you will find information on the different tiers.**

**[ ]  Tier One** **[ ]  Tier Two** **[ ]  Tier Three**

**[ ]  If Transitional Services are also being requested please complete below:**

* **Has this person received Transitional Services in the past 3 years?** **[ ]  Yes** **[ ]  No**
* **Services identified/needed:** **[ ]  Assistance coordinating/setting up the move** **[ ]  Household Items/Furniture**

**[ ]  Application Fee** **[ ]  Damage Deposit**

**Please include and email a copy of a current CSSP/CSP along with this referral.**

**Current Housing Type:** **[ ]  Apartment/Home** **[ ]  Nursing Home** **[ ]  Assisted Living** **[ ]  Foster Home** **[ ]  Homeless**

**Address:**

**Phone:**

**Email:**

**What City/Area/County is the consumer interested in moving to (HAC/HSS)?**

**Primary Disability(ies):**

**Are there currently any animals living in the home of this referral? [ ]  Yes [ ]  No [ ]  Unsure**

* **If Yes, please identify:**

**Services requesting – please identify what services and areas for outcomes that this consumer would like to or benefit from working on:**

**Own Guardian/Legal Representative: [ ]  Yes [ ]  No**

**Guardian/Legal Representative Name and Phone Number:**

**Guardian Email:**

**Any scheduling conflicts to work around? (School/work/treatment/etc.)**

**Any potential challenges/barriers to finding housing?**

**Current source(s) of income (SSI, SSDI, Wages, etc) and Amounts:**

**Date of Birth:** **Gender:** **[ ]  Male** **[ ]  Female** **[ ]  Other**

**County Case Manager and Phone Number:**

**County Case Manager Email:** **County of Financial Responsibility:**

**Waivered Service:** **[ ]  CADI** **[ ]  DD** **[ ]  TBI** **[ ]  DD/SILS** **[ ] RSC-TCM** **[ ]  CDCS** **[ ]  Pending** **[ ]  None** **[ ] Other \_\_\_\_\_\_\_\_\_**

**Other Information that would be important to know in regards to this referral:**

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**Independent Lifestyles - On-Call/24 Hour Emergency Assistance “Tier” Plan**

**Tier One - $30.00/daily rate stipend**

* Completion of 245D Paperwork: which includes intake paperwork at service initiation, assessment at 45 day to evaluate how services are going and then again annually thereafter or as needed throughout the year.
* Consumer Orientation/Training which includes: hands on orientation/training, magnet with phone number, assist with programming on-call number into phone and other areas of training as identified based on the consumer’s individual needs.
* Basic On-Call 24 Hour Emergency Assistance (per DHS requirements)
	+ Provide the consumer with on-call counseling and problem solving and/or immediate response for assistance at a person's home due to a health or personal emergency. In regards to providing an “immediate” response to go to a consumer’s home this will be determined based on the situation.
	+ Staff will triage the situation and get 911 assistance to the consumer if needed.
* On-Call Staffing which includes: 245D trained (required through MN DHS) as well as trained on each consumer’s plan for services.
* An “Emergency, Safety and Preparedness Manual” will be provided to each consumer.
	+ If the consumer is also active with ILS/SLS/IHS/etc. then the IL Specialist working with the consumer will teach/train the consumer on the materials in the manual.

**Tier Two - $45.00/daily rate stipend**

* Everything listed and identified in Tier One
* Daily Check-In’s which may include but are not limited to the following: **safety/safety awareness, overall health (mental, physical, emotional, social, etc.), home management/maintenance, etc.** and other areas as requested and developed in each consumers CSSP Addendum and will include areas identified based on the consumer’s individual needs. These Check-In’s can be completed via the phone (verbal or text messages), skype and Facetime as appropriate and available through other means of technology if identified.

**Tier Three - $60.29/day or daily stipend rate per county**

* Everything listed and identified in Tier Two
* Scheduled Reminders Calls which may include but are limited to the following: **medical/dental appointments, employment/related activities, transportation reminders, medication reminders, medication motivation, blood sugar/glucose checks, etc**. and other areas as identified and based on the consumer’s individual needs. These reminder calls can be completed via the phone (verbal or text messages), skype and Facetime as appropriate and available through other means of technology if identified.