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

H005 - CERTIFIED RESIDENTIAL OPPORTUNITIES (CRO) REFERRAL

Clear Form

Instructions: The Care Manager/referral source must fully explore with the person and family all less restrictive/less intensive residential habilitative options prior to making a referral for services in a residential facility certified or operated by OPWDD . Once all other options have been thoroughly investigated and determined not to be viable, describe these efforts in Section B of this form and proceed with this referral.

For the **initial request** of Certified Housing: Complete this form in full and submit all required supporting documents listed in section D. For **annual updates and/or circumstantial updates**: Complete section C and any other appropriate sections and submit all required supporting documents listed in Section D. Send all documents to the OPWDD Certified Housing Team.

By submitting this packet the Care Manager/referral source confirms that the person is actively seeking services in a residential facility certified or operated by OPWDD. The Certified Housing Team will review and process residential referral packets to determine whether a person's needs are appropriate for a certified residential setting. If appropriate, the Certified Housing Team will designate a residential support category (Emergency Need, Substantial Need, or Current Need) utilizing OPWDD's Statewide Criteria. After the Certified Housing Team reviews the completed referral packet the person/family and Care Manager/referral source will receive a Notice of Decision (NOD.15) authorizing services in a residential facility certified or operated by OPWDD and a Notice of Residential Support Category form (will only go to the CM) OR Notice of Decision (NOD.15) NOT authorizing a certified setting.

- The following website might be of assistance with exploring housing alternatives: https://opwdd.ny.gov/types- services/housing. *These efforts must be described in section B of this form.*
- Incomplete referrals will be returned to the Care Manager/referral source. Missing information will be identified in Section F, located on this form.

PLEASE PRINT CLEARLY OR COMPLETE ELECTRONICALLY

A. BASIC DEMOGRAPHICS

Person's Name (Last, First): TABS ID: Willowbrook: OPWDD Eligibility Confirmed: If this is a referral update are you requesting the residential support category designation to be reviewed and changed?	DOB: Gender: Pronoun: (only if explicitly asked to share)	Street Address: City: State: Zip Code: County: If the person is currently living at a different address than above - List the County and OPWDD Region:

Assessments:

Has a Coordinated Assessment System (CAS) been completed?
If yes, CAS completion date:
If no, document the date CAS was requested:

Has a Child and Adolescent Needs and Strengths (CANS) assessment been completed?
If yes, CANS completion date:
If no, document the date CANS was requested:

ISPM Score: Adaptive Score: Date:
Health Score:
Behavior Score:

Current Diagnoses (list all):

Current Benefits

HCBS Waiver Enrollment:
If yes, Waiver Enrollment Date:

Medicaid:
If yes, Medicaid CIN:

SSI:
If in process, date submitted:

Housing Subsidy Program:

Current Living Situation:	Care Manager/Referral Source Name (*Last, First*):
Specify Agency, if applicable. Define other if selected above:	Care Coordination Organization/Agency/Other: Define other if selected above:
What is the person's current Level Of Supervision in their current home? **1:1 Supervision:** Support person must be close enough to the person to immediately respond to prevent or lessen the impact of harm **Range of Sight or Scan:** Support person is in the same general area as the person (within the direct or indirect visual field) close enough to efficiently respond **Periodic Checks:** Support person observes the person via sight or by sound within a set time-frame, support person response time as needed **Independent with Staff:** Support person is aware of the location of the person and support person is within a planned vicinity to assist the person, support person response time as needed **Independent:** Person does not require specified Level of Supervision	Phone Number: Email Address: Care Manager/Referral Source Supervisor Name (*Last, First)*: Care Manager/Referral Source Supervisor Email Address:

Is there a legally appointed guardian? Name (*Last, First*): Phone Number: Email Address: Mailing Address: *Court documentation of guardian's appointment required with this referral form.*	If no legally appointed guardian, is there an advocate/involved party? If yes, please select from the drop down: Specify other (*if applicable*): Name *(Last, First)*: Phone Number: Email Address: Mailing Address:
Current Primary Caregiver (*if different from above*) Name (*Last, First*): Phone Number: Email Address: Mailing Address (if different from applicant):	Relationship to the person? Specify other (if applicable):

B. INFORMATION ABOUT RESIDENTIAL CIRCUMSTANCES

1. Describe the person's current living situation (who resides in the home, relevant amenities, proximity to family, satisfaction with current home companionship/staffing:

2. Why is a new living situation being explored at this time?

3. What community/waiver services have been authorized? What authorized services are being received?

4. Could the needs of this person as described throughout the referral be supported in their current home or non-certified option with more support services in place? (*If yes, describe the suggested supports; If no, explain why extra supports would not suffice*.)

5. If there are identified concerns with current home, what efforts have been made to address these concerns? *(Include all types of interventions/support services attempted and the time frames such interventions were applied.)*

6. What types of living situation(s) has the person communicated interest?

7. Has the person communicated that they are open to, and willing to accept, a certified residential opportunity? If no, please explain:

8. Describe all efforts made to find the least restrictive, community-integrated housing opportunities prior to referring for a certified opportunity. List what was explored, dates, and the specific reasons the settings were not appropriate for the person.

C. DESCRIBE THE PERSON'S CURRENT STRENGTHS, NEEDS, AND RESIDENTIAL CONSIDERATIONS

Residential Considerations	Required	Preferred	N/A	Provide need/diagnosis/justification for all REQUIRED items:
1. Gender Specific Home	☐	☐	☐	If required, provide clinical justification:
2. County Preferences	☐	☐	☐	If a county is required, describe why; list counties preferred (if all counties are within one region only identify the region or district):

Residential Considerations	Required	Preferred	N/A	Provide need/diagnosis/justification for all REQUIRED items:
3. Type of Community	☐	☐	☐	☐ **City** - (walking distance to stores, food, parks, has sidewalks, mass- transportation, multi-family apartment buildings) ☐ **Suburb** – (drive to most stores and services, more parks and open spaces, less crowds, back yards, room for garden, limited access to public transportation) ☐ **Rural** – (small population, farms, little to no public transportation, have to drive to stores, no sidewalks) Describe Need:
4. Smoke Free Environment	☐	☐	☐	Describe Need:
5. Pets Allowed	☐	☐	☐	Describe the kind of pet the person currently has or wants to have:
6. Specific Dietary Needs	☐	☐	☐	Describe Need(s):
7. Secured Kitchen	☐	☐	☐	If food, utensils, and/or appliances need to be secured, explain:
8. Single Bedroom	☐	☐	☐	If required, provide clinical justification:

Residential Considerations	Required	Preferred	N/A	Provide need/diagnosis/justification for all REQUIRED items:
9. Communication Supports	☐	☐	☐	Specify language used – comment on the person's ability to read, write, speak, hear, and understand in this language, state if there is a preferred language/bi-lingual, state supports needed (include any type of adaptive equipment):
10. Barrier Free (Wheelchair accessible to bedroom, bathroom, dining area, and two evacuation points)	☐	☐	☐	Describe ambulation need(s):
11. Environmental Accessibility (ramped entrance, ground floor living, hand rails, etc.)	☐	☐	☐	Describe mobility need(s), include any type of adaptive equipment:
12. First Floor Bedroom	☐	☐	☐	Describe Need:
13. Special Shower/Tub Equipment	☐	☐	☐	Specify what type of bathing equipment is needed:
14. Special Lifts	☐	☐	☐	Specify what is being currently utilized:
15. Sensory Accommodations	☐	☐	☐	Flashing fire alarm light, shaker bed, tactile warning strips, access to braille books/usage of braille labels, books on tape, telecommunication relay service, etc.

Residential Considerations	Required	Preferred	N/A	Provide need/diagnosis/justification for all REQUIRED items:
16. Door/Window Alarms	☐	☐	☐	Specify what types of alarms are needed & describe behavior:
17. Bed Alarms	☐	☐	☐	Specify what types of alarms are needed & describe behavior:
18. Fenced Yard	☐	☐	☐	Describe Behavior:
19. Delayed Egress (Door system that postpones a door to open by seconds (time can vary) may also come with an audible alarm)	☐	☐	☐	Describe Behavior:
20. Sprinkler System	☐	☐	☐	Describe evacuation concerns:
21. Time Out Room	☐		☐	Describe behavior and status of fading plan:
22. Quiet Areas	☐	☐	☐	Describe Need:

Residential Considerations	Required	Preferred	N/A	Provide need/diagnosis/justification for all REQUIRED items:
23. Enhanced Clinical Support	☐	☐	☐	Describe behavioral concerns/target behaviors:
24. Support with Medicine Administration	☐	☐	☐	What supports are needed for medication administration? ☐ None/Independent ☐ Reminders (verbal or adaptive technology) ☐ Uses Pill Blister Packets ☐ Total Support List current medication and method (by mouth, injectable, topical, etc.):
25. Nursing Supports On Site Daily	☐	☐	☐	Nursing Support Hours: Describe medical condition for on-site nursing:

D. APPLICATION COMPLETION CHECKLIST: REQUIRED DOCUMENTATION

Confirm that the following documents are included in the referral packet by checking the boxes below

REFERRAL COMPLETE- a completed referral contains all of the documents listed below:

- ☐ Certified Residential Opportunities Residential Referral form (H005)
- ☐ Current Life Plan or other comprehensive plan (e.g., CFA, Treatment Plan, etc.)
- ☐ Current Physical Examination Report/Comprehensive Medical Report (within 365 days of medical exam)
- ☐ Psychological Report (reflective of current functioning level)

The following documents are required, if ever completed:

- ☐ Current Social History or Psychosocial Reports
- ☐ Documentation of Legal Guardianship (if applicable)
- ☐ Most recent OT/PT/Sensory/Speech and Language reports
- ☐ Most recent habilitation and/or functional communication teaching plan
- ☐ Most recent Individualized Education Plan (IEP) for those under 23, including Behavior Intervention Plan Staff Action Plan (including any referenced internal guidance document(s))
- ☐ Strength Based Referral Summary (for those transitioning from an ITO)
- ☐ Functional Behavior Assessment (previous assessment if no current assessment)
- ☐ Current Behavior Support Plan (previous plans if a current plan is not in place)
- ☐ Current behavioral data (if a BSP is in place)
- ☐ Risk Assessment/Risk Management Plan
- ☐ Forensic Reports (Parole/Probation conditions, Strict and Intensive Supervision and Treatment (SIST) conditions, Sex Offender Registration Act (SORA) status, Orders of Protection, Assisted Outpatient Treatment (AOT) conditions, etc.)
- ☐ Other Relevant Reports, Assessments, or Documents:

E. TO BE COMPLETED BY PERSON SUBMITTING THIS REFERRAL

By entering my name below I confirm that I have explained the residential referral process to the above named person and/or the family/legal representative. They acknowledged and understood that to address their request for a residential opportunity their personal information (Medical, Clinical, or other information) will be shared by OPWDD with agencies that provide residential services in order to identify an appropriate residential opportunity.

By entering my name below I confirm that I have explained to the person/family/legal representation, and they acknowledged and understood that OPWDD will make best efforts but cannot guarantee to find an opportunity in preferred geographic location or that will meet all specific requests.

By entering my name below I confirm that I have explained to the person/family/legal representation, and they acknowledged and understood that they have the right to withdraw their request for a residential opportunity at any time.

Date you spoke to the person and/or family/legal representative:	Date: Name: Relationship/Title: Phone Number: Email Address:

---- Submit complete residential referral packet to the OPWDD Residential Opportunities Team mailbox ----

F. REFERRAL INCOMPLETE: ADDITIONAL INFORMATION REQUIRED

☐ **REFERRAL INCOMPLETE**

Instructions for Regional Field Office: 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 Care Manager/referral source: if the Service Access, Program Implementation, & Stakeholder Support Regional Field Office (RFO) team has determined this referral to be incomplete, please submit the requested information below within 30 days. Resubmission must include this form and documentation indicated below.

Information below to be completed by SPSRFO Team

Date Referral Received: Date Reviewed:

SPSRFO Staff Name: Phone Number:

Referral incomplete, returned to CM/referral source Date:

Reason:

Additional Information:

☐ **Referral continues to be incomplete please see the requested information below and submit within 30 days.**

Date Referral Received: Date Reviewed: SPSRFO Staff Name: Phone Number:

Referral incomplete, returned to CM/referral source Date:

Reason:

Additional Information:

☐ **Referral continues to be incomplete please see the requested information below and submit within 30 days.**

Date Referral Received: Date Reviewed: SPSRFO Staff Name: Phone Number:

Referral incomplete, returned to CM/referral source Date:

Reason:

G. LEVEL OF NEED ASSIGNMENT
---TO BE COMPLETED BY SPSRFO--

Instructions for SPS Regional Field Office Staff: Once a completed referral is received/reviewed and a determination has been made to authorize services in a residential facility certified or operated by OPWDD, the Certified Housing Team will inform the referral source by completing and sending out the Notice of Decision (NOD.15) along with the H004 Notification of Residential Support Category form. If certified housing was NOT authorized the Certified Housing Team will notify the referral source by completing the NOD.15.

Date the Complete Referral was Received: Date Reviewed:

Certified Housing NOD: Date of NOD:

If authorized, Level of Need Determination: Date:

Rationale (Based on Statewide Criteria):
(Document the reason for the level assigned i.e. homeless or increasing risk to self or others, etc.)

No Level Assigned:

☐ Certified Residential Opportunity is not supported at this time, refer to NOD.15

RFO Staff Approving Level of Need: Date: