ELM Homes Referral Form

Applicant's Name: _____

Current Telephone: _____ Current Placement/provider: _____

Reason for transition to new placement? _____

_____

Birth Date: _____ Place of Birth: _____

Sex: _____ Age: ____ Height: _____ Weight: _____ Social Security Number: _____

Diagnosis: _____

_____

_____

_____

Ambulatory: ☐ Yes ☐ No Able to walk up and down stairs? ☐ Yes ☐ No

Does applicant have any assistive or adaptive devices (wheelchair, braces, walker, orthopedic shoes, splints, canes)? ☐ Yes ☐ No Type: _____

Marital Status: _____ Citizenship Status: _____ PMI #_____

Previous Residential Placements	Dates	Reason for Leaving

Current Day Placement: _____

Contact Person: _____

Address: _____ Phone Number: _____

Email Address: _____

Father's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Involved in applicant's life? ☐ Yes ☐ No

Email Address: _____

Mother's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Involved in applicant's life? ☐ Yes ☐ No

Email Address: _____

Guardian/Conservator: _____ Home Phone: _____

Relationship to applicant: _____ Cell Phone: _____

Address: _____

Email Address: _____

Case Manager: _____ County: _____

Relationship to applicant: _____ Office Phone: _____

Address: _____

Email Address: _____

Financial Information

Which of the following does the applicant receive for financial assistance?

Medical Assistance ☐ MA Number: _____

Medicare ☐ Medicare Number: _____

SSA/SSI ☐ Other (parents, etc.) ☐ _____

Is the applicant capable of carrying cash responsibly? ☐ Yes ☐No If yes, how much? _____

Is the applicant on a waiver established through a county case manager? ☐ Yes ☐ No

If yes, which waiver? _____

County of financial responsibility: _____

Financial Worker name and phone number: _____

Rep Payee and phone number: _____

Authorized Representative and phone number: _____

Behavioral Information

Does the person served have a history of:	
Physical Aggression	☐ Yes ☐ No
Verbal Aggression or Threats	☐ Yes ☐ No
Destroying Property	☐ Yes ☐ No
Eloping	☐ Yes ☐ No
Self-Injurious Behaviors Types: _____	☐ Yes ☐ No
Manipulation/Lying	☐ Yes ☐ No
Falsely Accusing Others of Maltreatment/Abuse	☐ Yes ☐ No
Sexual Inappropriateness	☐ Yes ☐ No
Refusing Meds	☐ Yes ☐ No
Criminal Court History If yes, explain:	☐ Yes ☐ No

Antecedents to behaviors? _____

_____

_____

How do others know he/she is anxious/annoyed/restless? _____

_____

_____

When they are anxious/annoyed/restless, what calms them? _____

_____

_____

Does the applicant have a Positive Support Transition Plan? Or has in the past? ☐ Yes ☐ No
If yes, please attach a copy.

Abuse

Does the applicant have a history of abuse?	☐ Yes ☐ No
Does the applicant have a history of abusing others?	☐ Yes ☐ No
Does the applicant have a history of abusing animals?	☐ Yes ☐ No

If yes to any of the above three questions, please explain: _____

_____

Supervision

Level of supervision needed? _____

Does the applicant have alone time at home or in the community? ☐ Yes ☐ No

If yes, please specify how much time in each setting: Home: _____

Community: _____

Does the applicant have restrictions on any visitors or people in their life? ☐ Yes ☐ No

If yes, please specify restrictions: _____

Does applicant attend family visits unsupervised? ☐ Yes ☐ No

ELM Homes provides asleep staff between the hours of 10p-6a. Is the applicant able to have sleep staff? ☐ Yes ☐ No

Is the applicant able to be alone with the opposite sex? ☐ Yes ☐ No

Is the applicant able to live with the opposite sex? ☐ Yes ☐ No

Medical Section

Current Physician: _____ Date of last exam: _____

Address: _____

Phone Number: _____

Current Dentist: _____ Date of last exam: _____

Address: _____

Phone Number: _____

Current Optical Doctor: _____ Date of last exam: _____

Address: _____

Phone Number: _____

Current Audiological: _____ Date of last exam: _____

Address: _____

Phone Number: _____

Current Specialist: _____ Date of last exam: _____

Address: _____

Phone Number: _____

Current Psychiatrist: _____ Date of last exam: _____

Address: _____

Phone Number: _____

Current Counselor/Therapist/Psychologist: _____ Date of last exam: _____

Address: _____

Phone Number: _____

Current Medications:

Name of Medication	Dose	Frequency	Reason for Medication

Allergies: _____

Medical History:

List all operations/injuries/illnesses the applicant has experienced which required hospitalization? *Use back side to list additional hospitalizations.

Date	**Nature of Hospitalization**	**Name and Address of Hospital**

Is applicant prone to any of the following?

Urinary Tract Infections	☐	Colds	☐	Strep Throat	☐
Asthma	☐	Diarrhea	☐	Weight Loss/Gain	☐

Does the applicant require licensed nursing services? ☐ Yes ☐ No

Does the applicant require specialized medical services/Appointments (oxygen, insulin, speech therapy, etc.)? ☐ Yes ☐ No
If yes, explain: _____

Is the applicant on a special diet as ordered by a physician? ☐ Yes ☐ No Type: _____

Does the applicant have any diet restrictions? _____

Does the applicant have seizures? ☐ Yes ☐ No Date of last seizure: _____

Frequency/Description of seizures: _____

Illness: (indicate month and year)

Chicken Pox:	_____	Whooping Cough:	_____	Hepatitis B:	_____
Measles:	_____	Rheumatic Fever:	_____	Diabetes:	_____
Mumps:	_____	Polio:	_____	HIV/AIDS:	_____
Scarlet Fever:	_____	Croup:	_____	Hepatitis A:	_____
German Measles:	_____	Tuberculosis:	_____	Other:	_____

Methicillin-Resistant Staphylococcus Aurous (MRSA): _____

Vancomycin-Resistant Enterococci (VRE): _____

Screenings

Date of last Mantoux: _____

Has the applicant ever had a positive Mantoux: ☐ Yes ☐ No

Date/Results of last chest X-Ray:
_____

Hepatitis Screening: Date: _____

Antigen result: _____ Antibody result: _____

Laboratory test for HIV/AIDS: Date: _____

HTLV-III antibodies present? ☐ Yes ☐ No

Immunizations

	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose	Booster
	Mo.-Yr.	Mo.-Yr.	Mo.-Yr.	Mo.-Yr.	Mo.-Yr.	Mo.-Yr.
DTaP Series						
IPV (Polio)						
Hib (Haemophilus influenza)						
PCV Pneumococcal						
Gardasil (HPV)						
Hepatitis B						
MMR (Measles, Mumps, Rubella)						
Varicella (Chicken Pox)						
Hepatitis A						
Influenza						

Other

Is there anything else ELM Homes should know that would assist us to better serve the applicant? _____

_____

_____

What goals or outcomes does the applicant and/or team want him/her to work on? _____

_____

_____

Attachments

Please attach the following forms, if applicable:

- ☐ CSP/ISP
- ☐ IAPP
- ☐ ISSA
- ☐ Most current psychological evaluation
- ☐ Discharge from previous placement
- ☐ Person Centered Plan

Please email form to Jocelyn Heyer, Executive Director at jocelyn.heyer@elmhomes.org or fax to (507) 835-4574.

This Referral Form was completed by: _____ Date: _____