Ohio Department of Developmental Disabilities

Pre-Admission Counseling Referral Form

For individuals seeking new admission to facilities with nine beds or more. Not for transfers.

Individual Name		Birth Date	
Street		City	
County of Residence	<blank>	Zip	
Medicaid Number		SSN	
Home Phone		Cell Phone	

Guardian Information

Guardian Name			
Street		City	
County	<blank>	Zip	
Phone number		Cell Phone	
Email			
I verify that I am considering accepting the next available placement opportunity at:			
Individual/Guardian Signature			Date

Proposed ICF Provider Information

ICF Name		Certified Capacity of ICF		Medicaid Provider No.	
Contact Person		Phone No.			
Street		Email			
City		Anticipated Vacancy Date			
County	<blank>	Date of Referral to County Board			
Zip					

I verify that the individual listed above is being considered for the vacancy date specified.	
Signature of ICF Representative	Date

Pre-Admission Counseling Referral Form

County Board Pre-Admission Interview

Name of County Board Representative			Select County Board	<blank>
Date Referral Received		Date of Interview		

Name and relationship of those attending the meeting. *Face-to-face interview with individual seeking services is required.*

Does the individual meet criteria for emergency status as specified in OAC 5123:2-1-08? *Follow local process for emergency status.*	Yes ☐ No ☐

List the person's preference in the five areas below.

1. In what type of setting does the person want to live?
2. With whom does the person live?
3. What work or other valued activity does the person want to do?
4. With whom does the person want to socialize?
5. In what social, leisure, religious or other activities does the person want to participate?

Pre-Admission Counseling Referral Form

	Supported currently provided by	Is new or additional support needed?	This additional support is available in	Type of community support currently available
Hands on assistance with care	<blank>	<blank>	<blank>	<blank>
Transportation	<blank>	<blank>	<blank>	<blank>
Employment or day services	<blank>	<blank>	<blank>	<blank>
Respite or caregiver relief	<blank>	<blank>	<blank>	<blank>
Adaptive equipment	<blank>	<blank>	<blank>	<blank>
Home modifications	<blank>	<blank>	<blank>	<blank>
Assistance with medications	<blank>	<blank>	<blank>	<blank>
Other nursing needs	<blank>	<blank>	<blank>	<blank>
Therapy <blank>	<blank>	<blank>	<blank>	<blank>
Prevention of harm to self	<blank>	<blank>	<blank>	<blank>
Prevention of harm to others	<blank>	<blank>	<blank>	<blank>

What strengths or resources does the person have that could contribute to his or her success in their community?

What are the barriers to the person's successful community living? *Select all that apply.*		
☐ Lack of willing or qualified providers	☐ Requires change of residence	☐ Other

If a change in residence is required list the reasons.

State or list efforts to remove the barriers noted above.

What supports were in place before the referral and what were the reasons they were not successful?

List all community options discussed with the person.

Upon review of available options, the person prefers to proceed with	☐ ICF ☐ HCBS	Date sent to DODD	