B&D Services, Inc. Referral for Services

B&D Services, Inc. requires completion of all the following information for individuals requesting consideration for services. The information will be kept confidential in accordance with Federal and State Confidentiality Laws and HIPAA requirements.

B & D SERVICES, INC.
Community Living Program

Referral Information

Today's Date: _____ **Legal Name:** _____
(First) (Middle) (Last)

Preferred Name (Goes By): _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female ☐ _____ **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security #: _____ **State ID #:** _____ **MCO #:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email:** _____

Primary Diagnosis: _____

For Individuals being referred who have a Legal Guardian:

*If an individual has a legal guardian and is over 18 years old, a copy of guardianship paperwork must be obtained before beginning services.

Legal Guardian Name: _____ **Relationship:** _____

Guardian Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email:** _____

For Individuals being referred who have a caregiver other than a Legal Guardian:

Caregiver Name: _____ **Relationship:** _____

Caregiver Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email:** _____

For Individuals being referred who have a Power of Attorney:

*If an individual has a legal POA, a copy of the POA paperwork must be obtained before beginning services.

Type of POA: ☐ Financial only ☐ Medical Only ☐ Both Financial & Medical ☐ None, but in the process

POA Name: _____ **Relationship:** _____

POA Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email:** _____

If the Individual being referred has a Court-Ordered Committal or Legal Restrictions, please describe:

*If an individual has a court ordered committal or legal restriction, a copy of this paperwork must be obtained before beginning services.

Services Requested

Reason for Referral: _____

☐ Child Services
☐ Adult Services

☐ Hourly Services
☐ 24-hour Services

Hourly Services Requested:
(Select all that Apply)

☐ SCL
☐ Habilitation
☐ Individual Respite
☐ Other: _____
☐ IMMT
☐ Homemaker
☐ CDAC

Habilitation Tier Assigned:

☐ UA
☐ UB
☐ UC
☐ UD
☐ U7
☐ U8
☐ U9
☐ None Yet

SCL Daily Tier Assigned:

☐ Tier 1
☐ Tier 2
☐ Tier 3
☐ Not yet assessed
☐ Tier 4
☐ Tier 5
☐ Tier 6

Funding Source/MCO:

☐ Wellpoint
☐ Iowa Total Care
☐ Molina
☐ Regional Services
☐ Other: _____
☐ FFS/Iowa Medicaid
☐ NEI3A Funding
☐ Private Pay

Waiver/Service: (Select all that Appy)

☐ HCBS/ID Waiver (Intellectual Disability)
☐ HCBS/BI Waiver (Brain Injury)
☐ HCBS/PD Waiver (Physical Disability)
☐ Other: _____
☐ HCBS/H&D Waiver (Health & Disability)
☐ HCBS/Elderly Waiver
☐ Habilitation

Referral Source

Relationship to Individual Being Referred:

☐ Case Manager
☐ Social Worker
☐ Self
☐ Guardian
☐ Other: _____
☐ Family Member
☐ Friend
☐ B&D Services Employee
☐ B&D Services Client
☐ Healthcare Professional
☐ Teacher/School Employee
☐ Justice Services

Name of Person Referring the Individual: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email:** _____

For Individuals being referred who have a Case Manager:

Case Manager Name: _____ **Organization/ Agency:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Office Phone #:** _____ **Email:** _____

I hereby acknowledge that all information in this document is accurate to the best of my knowledge. I understand additional documentation may need to be obtained for B&D Services, Inc. to determine if our services fit the needs and/or to determine eligibility for services of the individual you are referring. I understand an intake meeting must be held with the individual prior to services beginning. I understand that I am required to notify B&D Services, Inc. in writing of any changes to this document.

Signature: _____ **Date:** _____

Thank you for your referral. Referrals are processed within 5 business days of receipt.

To access services, all needed documents must be obtained, and an intake must be conducted with the individual.

Supporting documentation is often required to help us determine if our services fit the needs of the individual you are referring. Please note all HCBS Waiver Referrals must submit a current Social History and Functional Assessment to be processed. Supporting or required documentation may include:

☐	Release of Information	☐	Educational IEP
☐	Social History	☐	Legal Guardianship Documents
☐	Functional Assessment	☐	POA Documents
☐	Current Service Plan	☐	Court Committals or other Legal Restrictions
☐	Psychological Evaluation	☐	Copy of Photo Identification
☐	Healthcare Evaluations or other proof of disability	☐	Copy of Insurance Card
☐	Current Medication List		

Please submit referrals and supporting documents to:

Kira Roberts, Program Director
B&D Services, Inc.
Email: kira@bdclp.com
Phone: (319) 334-6997
Fax: (319) 334-3351
Address: 212 1st St. East, Independence, IA 50644