

# 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.



## 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:** \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Child Services | <input type="checkbox"/> Hourly Services  |
| <input type="checkbox"/> Adult Services | <input type="checkbox"/> 24-hour Services |

- |  |  |   |
|--|--|---|
| <b>Hourly Services Requested:</b><br>(Select all that Apply)<br><input type="checkbox"/> SCL <input type="checkbox"/> IMMT<br><input type="checkbox"/> Habilitation <input type="checkbox"/> Homemaker<br><input type="checkbox"/> Individual Respite <input type="checkbox"/> Supported Employment<br><input type="checkbox"/> Other: _____ | <b>Habilitation Tier Assigned:</b><br><input type="checkbox"/> UA <input type="checkbox"/> U7<br><input type="checkbox"/> UB <input type="checkbox"/> U8<br><input type="checkbox"/> UC <input type="checkbox"/> U9<br><input type="checkbox"/> UD <input type="checkbox"/> None Yet | <b>SCL Daily Tier Assigned:</b><br><input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 4<br><input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 5<br><input type="checkbox"/> Tier 3 <input type="checkbox"/> Tier 6<br><input type="checkbox"/> Not yet assessed |
|--|--|---|

- |   |   |
|---|---|
| <b>Funding Source/MCO:</b><br><input type="checkbox"/> Wellpoint <input type="checkbox"/> FFS/Iowa Medicaid<br><input type="checkbox"/> Iowa Total Care <input type="checkbox"/> NEI3A Funding<br><input type="checkbox"/> Molina <input type="checkbox"/> Private Pay<br><input type="checkbox"/> Regional Services<br><input type="checkbox"/> Other: _____ | <b>Waiver/Service:</b> (Select all that Apply)<br><input type="checkbox"/> HCBS/ID Waiver (Intellectual Disability) <input type="checkbox"/> HCBS/H&D Waiver (Health & Disability)<br><input type="checkbox"/> HCBS/BI Waiver (Brain Injury) <input type="checkbox"/> HCBS/Elderly Waiver<br><input type="checkbox"/> HCBS/PD Waiver (Physical Disability) <input type="checkbox"/> Habilitation<br><input type="checkbox"/> Other: _____ |
|---|---|

**Referral Source**

- |  |  |  |
|--|--|--|
| <b>Relationship to Individual Being Referred:</b><br><input type="checkbox"/> Case Manager <input type="checkbox"/> Family Member <input type="checkbox"/> Healthcare Professional<br><input type="checkbox"/> Social Worker <input type="checkbox"/> Friend <input type="checkbox"/> Teacher/School Employee<br><input type="checkbox"/> Self <input type="checkbox"/> B&D Services Employee <input type="checkbox"/> Justice Services<br><input type="checkbox"/> Guardian <input type="checkbox"/> B&D Services Client<br><input type="checkbox"/> Other: _____ |  |  |
|--|--|--|

**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:**

<input type="checkbox"/>	Release of Information	<input type="checkbox"/>	Educational IEP
<input type="checkbox"/>	Social History	<input type="checkbox"/>	Legal Guardianship Documents
<input type="checkbox"/>	Functional Assessment	<input type="checkbox"/>	POA Documents
<input type="checkbox"/>	Current Service Plan	<input type="checkbox"/>	Court Committals or other Legal Restrictions
<input type="checkbox"/>	Psychological Evaluation	<input type="checkbox"/>	Copy of Photo Identification
<input type="checkbox"/>	Healthcare Evaluations or other proof of disability	<input type="checkbox"/>	Copy of Insurance Card
<input type="checkbox"/>	Current Medication List		

**Please submit referrals and supporting documents to:**

**Raelinn Ritze, Program Director**

**B&D Services, Inc.**

**Email: [raelinn@bdclp.com](mailto:raelinn@bdclp.com)**

**Phone: (319) 334-6997**

**Fax: (319) 334-3351**

**Address: 212 1st St. East, Independence, IA 50644**