Compass Community Services, Inc.

REFERRAL & INTAKE FORM

Compass Community Services, Inc. | Confidential — Participant Record

INSTRUCTIONS: Complete all applicable sections. All fields marked with an asterisk (*) are required. Submit completed form to Compass Community Services along with required documentation. No services may begin without completed intake documentation and verified authorization.

Date of Referral:	
Referred By:	
Referral Source:	☐ Care Coordinator ☐ MCO (Alliance/Partners) ☐ Family/Guardian ☐ Community Org ☐ Self-Referral ☐ Other:
Intake Assigned To:	
Intake Date:	
Target Service Start Date:	

Section 1: Participant Information

* Legal Full Name (Last, First, MI):	
*** Date of Birth:**	
*** Medicaid ID:**	
Social Security Number (last 4):	
*** Gender:**	☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to State ☐ Other: ___
*** Primary Language:**	
Interpreter Needed?	☐ Yes — Language: ____________________________ ☐ No
Race/Ethnicity (optional):	

*** Primary Diagnosis (IDD/TBI):**	
Secondary Diagnoses (if any):	
*** Primary Address:**	
City, State, ZIP:	
*** County of Residence:**	
Home Phone:	
Cell Phone:	
Email (if applicable):	

Section 2: Guardian / Authorized Representative

Is Participant Their Own Legal Guardian?	☐ Yes — skip to Section 3 ☐ No — complete below
Legal Guardian / Representative Name:	
Relationship to Participant:	
Phone (Primary):	
Phone (Alternate):	
Email:	
Address (if different from participant):	
Legal Guardianship Documentation on File?	☐ Yes — attached ☐ Pending ☐ Not applicable
Power of Attorney on File?	☐ Yes — attached ☐ No

Section 3: Managed Care Organization & Care Coordinator

* MCO (Managed Care Organization):	☐ Alliance Health ☐ Partners Health Management ☐ Other: ___________
* Care Coordinator Name:	
* Care Coordinator Phone:	
Care Coordinator Email:	
Care Coordinator Organization / Agency:	
* Current Service Authorization on File?	☐ Yes — Authorization #: ____________________ ☐ Pending
Authorization Effective Date:	
Authorization Expiration Date:	
Current PCP on File?	☐ Yes — Date: _______________________ ☐ Pending from Care Coordinator

Section 4: Services Requested

Services Being Requested:	☐ Community Living & Supports (CLS) ☐ Supported Employment ☐ Respite (Home-Based)
Authorized Hours per Month (CLS):	
Authorized Hours per Month (Supported Employment):	
Authorized Hours per Month (Respite):	
Preferred Service Days:	☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
Preferred Service Times:	☐ Morning ☐ Afternoon ☐ Evening ☐ Flexible
Primary Service Location:	☐ Participant's Home (Respite only) ☐ Community Settings ☐ Employment Sites
Transportation Needed?	☐ Yes ☐ No ☐ Some sessions
Requested Start Date:	

Section 5: Health, Safety & Support Needs

Primary Care Physician:	
Physician Phone:	
Current Medications:	
Medication Management Needs:	☐ Independent ☐ Prompts needed ☐ Staff assist ☐ N/A
Known Allergies (medication/food/environmental):	
Seizure Disorder?	☐ Yes — Protocol: ______________________ ☐ No
Mobility/Physical Support Needs:	☐ None ☐ Minimal assistance ☐ Full assistance ☐ Adaptive equipment required
Communication Method:	☐ Verbal ☐ AAC Device ☐ Sign Language ☐ Picture Communication ☐ Other: ___
Behavioral History Relevant to Safety:	☐ Yes — Describe below ☐ No
Active Behavior Support Plan?	☐ Yes — attach ☐ No
Elopement Risk?	☐ Yes — Level: ____________ ☐ No
History of Abuse, Neglect, or Exploitation?	☐ Yes (noted in file) ☐ No ☐ Unknown
Any Pending Legal Matters Relevant to Services?	☐ Yes — describe: _________________ ☐ No

Behavioral Safety Notes (describe any history relevant to service delivery):

____

Section 6: Emergency Contacts

Contact Type	Name	Relationship	Phone (Primary)	Phone (Alt)
Primary Emergency Contact				
Secondary Emergency Contact				
Preferred Hospital (if any):				
Preferred Funeral Home (if applicable):				

DNR / Advance Directive on File?	☐ Yes — copy attached to record ☐ No
Medical Power of Attorney?	☐ Yes — copy attached ☐ No

Section 7: Previous Services & Transition Information

Previously Received IDD/TBI Services?	☐ Yes ☐ No
Previous Provider (if applicable):	
Reason for Leaving Previous Provider:	
Previous Incident History Relevant to Service:	☐ Disclosed — see documentation ☐ None reported
Previously Received Compass Services?	☐ Yes — prior record on file ☐ No
Transition Support Needed?	☐ Yes ☐ No
Special Transition Considerations:	

Section 8: Intake Determination & Admission Decision

Eligibility Verified?	☐ Yes ☐ No — Reason: ______________________________
Diagnosis Confirmed (IDD/TBI)?	☐ Yes ☐ No
Medicaid Active & Verified?	☐ Yes ☐ No
Service Authorization Received?	☐ Yes ☐ Pending — Expected: _____________ ☐ No
PCP Received?	☐ Yes ☐ Pending — Expected: _____________ ☐ No
All Required Documentation Complete?	☐ Yes ☐ No — Missing: ___________________________
Can Compass Meet Participant's Needs Safely?	☐ Yes ☐ No — See notes
ADMISSION DECISION:	☐ ADMITTED ☐ DENIED ☐ PENDING — Awaiting: ______________________

If Denied — Reason and Alternative Resources Provided:

____

Assigned DSP:	
Assigned Program Supervisor:	
Target Service Start Date:	
Care Coordinator Notified of Admission Decision:	☐ Yes — Date: ____________ ☐ No
Guardian Notified of Admission Decision:	☐ Yes — Date: ____________ ☐ No

Completing Staff Signature

QP / Intake Coordinator Signature: ______________________________ **Date:** ______________________________

Program Supervisor Signature: ______________________________ **Date:** ______________________________

Participant / Guardian Acknowledgment of Admission:

Participant Signature: ______________________________ **Date:** ______________________________

Guardian/Representative Signature (if applicable): ______________________________ **Date:** ______________________________

Documentation Checklist — Required Prior to Service Start

☐ Completed Intake Form (this form) ☐ Current PCP on file ☐ Service Authorization received

☐ Consent for Services signed ☐ Rights Acknowledgment signed (Form 10A)

☐ HIPAA Notice acknowledged (Form 12A) ☐ Release of Information signed

☐ Emergency Treatment Authorization signed ☐ Emergency Contacts documented

☐ Background check complete (staff) ☐ DSP orientation complete (Form 9B)

☐ **All documents filed in participant record — Signed by QP: ____________________ Date: ________________**