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| cid:image002.jpg@01DA9C9B.873348C0 | **Residential Provider Response Form** |

**Instructions for Plan Coordinators**

1. Complete the first section of this form and include it when making residential referrals.
2. The provider documents their response and returns the form to the referral source for upload in iRecord.

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| **Identifying Information** *Completed by referral source.* |
| Individual: Enter text.DDD ID: Enter text. | Date: Enter a date. |
| Support Coordination Agency or Division Unit: Enter text. |
| Plan Coordinator: Enter text. | Phone number: Enter text.Email address: Enter text. |
| Referral information (i.e. provider name / program names): Enter text. |

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| **Please check one:** *Completed by Residential Provider after reviewing the referral package.* |
| [ ]  We will offer services to this individual. |
| Name of program: Enter text. Licensing VID / Program ID #: Enter text.Address: Enter text. |
| Has a *Combined Application to Become a Medicaid/DDD-Approved Provider* been approved for this site? Yes [ ]  No [ ]  |
| Date available for admission:This opportunity will be held for this individual until: | Enter text.Enter text. |
| *Until this date, the placement will not be offered to another Individual.* |
| [ ] We require additional information and/or an in-person meeting in order to make a determination. |
| Please explain: Enter text. |
| *After review of additional information, the Residential Provider submits an updated Response Form.* |
| [ ]  We are unable to offer services at this time. The reason for this determination is (check all that apply): |
| [ ]  Individual/legal guardian declined or not interested[ ]  Staffing challenges/staffing insufficient to meet Individual’s needs[ ]  Behavioral support needs  | [ ]  Supervision needs [ ]  Tier concerns[ ]  Other |
| Please explain: Enter text. |
| **Completed by*:***  |
| Residential Provider: Enter text. |
| Residential Provider representative:Enter text.Title: Enter text. | Date: Enter a date. |
| Phone number: Enter text. |
| Email address: Enter text. |
| *Please return the completed form to the referral source named above.* |