
Beacon Specialized Living Services, Inc.
Initial Referral Information

Please send the referral back to Jennifer Milliken at fax number: 269-427-6027

If you have any questions, please call Jennifer's cell phone at 269-365-3815
or email: JMilliken@beaconserv.org

Or you may contact our corporate office at 269-427-8400
or email:

The PDF version is on our website link: <http://www.beaconspecialized.org/Contact-1.php>

CONFIDENTIAL

Persons completing this document and the Persons receiving the disclosed information may only further disclose consistent with the authorized purpose for which it is intended or disclosed. (MH 1748-[3])

Please answer the following questions related to the Consumer:

FIRST NAME: _____ MIDDLE: _____ LAST: _____

DATE OF BIRTH: _____ SSN: _____ GENDER: _____

RACE: _____ MARITAL STATUS: _____ CLIENT REF#: _____

VETERAN STATUS: _____ IS THERE A SURVIVING SPOUSE/ CHILD OF VETERAN: _____

PRIMARY LANGUAGE: _____

FUNERAL PROVISIONS, if applicable: _____

COURT ORDER? _____ IF SO, TYPE: _____ EXPIRES: _____

COUNTY WHICH ORDER WAS ISSUED?: _____

FUNERAL PROVISIONS AND PREFERENCES: _____

RELIGIOUS PREFERENCE: _____

CURRENT RESIDENCE/ADDRESS/PHONE: _____

REFERRAL SOURCE CONTACT:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

PHYSICIAN:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

PSYCHIATRIST:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

RESPONSIBLE AGENCY:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

CASE MANAGER:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

EMERGENCY CONTACT:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

NEXT OF KIN:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

GUARDIAN:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

PAYEE/CONSERVATOR:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

DIAGNOSIS:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

DIET: _____ ALLERGIES: _____

CONTRACTED SERVICES:

- | | |
|---|--|
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Behavior Treatment Plan |
| <input type="checkbox"/> Psychiatric Services | <input type="checkbox"/> Group Counseling |
| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Enhanced Staffing |
| <input type="checkbox"/> Dialectical Behavior Therapy | |

**If Enhanced Staffing,
Explain:** _____

ADVANCED DIRECTIVES:

Does Individual have an Advanced Directive? YES or NO If Yes, attach a copy.

Is there a Psychiatric Advance Directive? YES or NO If Yes, attach a copy

Does the Individual currently have Medicaid and/or Social Security Benefits? Y or N
(if the Individual does have Benefits, please include Policy Number & Types of Policies)

Will Beacon Staff need to assist Individual in applying for Benefits? Y or N

Medicaid: Medicaid Number/Plan: _____

Spend down? Y or N If yes, amount? _____

Medicare: Part A _____

Part B _____

Part C _____

Part D _____

Medicare Advantage Plan: _____

Private Insurance *(name of plan and ID number):* _____

Does this Individual have current insurance cards (not copies)? Y or N

If no, can physical cards be requested? Y or N

Does Individual receive SSI (Supplemental Security Income)? Y or N

If so, how much do they receive a month?: _____

Does this individual have a valid state ID? Y or N

Is Individual under 26 years of age? Y or N

If so, would they be interested in the School Program? Y or N

Current IEP (Individualized Education Program)? Y or N
(please attach copy or give us the last known school attended)

Is the Individual a Diabetic? Y N

If Yes, does the Individual have a Guardian? Y N

Any Medication Compliance Issues? Y N

Explain: _____

Is the Individual a Suicide Risk? Y N

Is the Individual a Threat or Danger to others? Y N

Does the Individual have Thoughts of Harm to others? Y N

Has the Individual had any recent Threatening Behaviors? Y N

Is there any presence of other High Risk Behaviors? (ie: cutting, head hanging, elopement, self injurious behavior, poor or dangerous relationships, risk taking, etc...) Y N

Does this Individual appear to be compatible with other individuals in the home?

Are there any foreseeable problems? Y N

Does this Individual require continuous nursing care? Y N

Does this Individual require isolation for medial purposes? Y N

Does this Individual require seclusion or restraint? Y N

Does this Individual currently present an immediate danger to themselves or others?

Is this an Individual who requires shelter only? Y N

What amount Personal Care does this Individual need? *Write in the amount of Personal Care the Referral Source indicates the Individual needs.*

What amount of Supervision does this Individual need? *Examples of this would include supervision when in the community, line of sight, one on one*

What amount of Protection does this Individual need? *Include whether the Individual has a high potential of being a victim of abuse.*

What kind of Skills does the home need to have available to meet this Individuals needs?
Examples: nurse, social worker, therapist, gentle teaching, etc...

What kind of Physical Accommodations does the home need to have to be able to meet this Individuals needs? *Examples: alarms, fence, staffing levels, handicap accessibility, etc...*

PLEASE ATTACH THE FOLLOWING REQUIRED DOCUMENTS IF AVAILABLE:

Guardianship Paperwork
Health Care Appraisal
Current Psychiatric Evaluation
Any Psychological Assessments, etc.
Current Prescriptions
Clinical Certifications
Treatment Orders
Current Medication List, if applicable
Current Person Centered Plan
Behavior Plan, if applicable

Note: (If Individual is to be placed behind a fence, a Behavior Plan is required upon Admission)

Community Access

Will this individual have independent community access at the time of intake?

Y or N

If yes, how many hours per day/ per week will this individual be able to access the community independently?

Beacon Specialized Living Services, Inc. community access guidelines:

The Resident must sign in and sign out with facility staff upon leaving and returning from community access.

The Organization is not responsible for transportation to, or from community access.

The resident is responsible for being present for all medication passes.

Resident to staff ratio will be maintained and elopement policies will be followed identically to facility policies unless otherwise indicated in the individual's plan.

Staff will maintain routine checks during supervised community outings, unless stated otherwise in individual's plan.

RESIDENT ADMISSION CHECKLIST

Please ensure the following items are accounted for at time of pick-up.

Resident Name: _____ Weight _____ Height _____

- Photo ID
- Insurance Cards and/ or Copy of Insurance Cards

Medications:

- Copy of Prescriptions Epi-Pen (if applicable)
- Attach Medication List

Name of Pharmacy where Prescriptions were filled

Medical Equipment:

- C-Pap or Bi-Pap

If Diabetic:

- Glucometer Test Strips Lancets
- Needles/ Syringes

Who supplies this equipment? (Local Pharmacy, Binsons, Healthy Living, etc.)

If on Oxygen:

- Concentrator Back-up Tank Tubing
- Mask and/ or Nasal Cannula

If has Nebulizer:

- Nebulizer Tubing Mask
- Medication for Nebulizer

Assistive Devices:

- Walker Cane Wheelchair
- Crutches Shower Chair Eye Glasses
- Dentures Incontinence Supplies (Adult Diapers, etc.)
- Gait Belt

Who is the supplier of the incontinence products? _____

Has individual been using a hospital bed? Yes No

Does this individual use a hoyer, and if so do they have one of their own?

- Yes No

Other Equipment/ Medical Supplies: _____

Are there Prescriptions/ Order to use these supplies? Yes No

Case Manager Signature: _____ Date: _____