BEACON Specialized Living

Referral Packet

Please send referrals back to:
referrals@beaconspecialized.org or
fax to (866) 407-0531

Due to the high volume of referrals that Beacon Specialized Living receives, we ask that once a client has been accepted to our program that CMH/guardian have appropriate paperwork completed and signed within 5 business days. This will ensure our process can continue to operate efficiently and we can continue to provide the most expedient placements for your clients. If completed paperwork is not able to be received within 5 business days, Beacon will have to proceed with the next referral in line as we DO NOT promise a bed hold.

Attached in our Referral Packet is our Service Authorization Form, regarding services that will be authorized at time of placement. This must be signed by all parties.

Beacon DOES NOT bill Medicare/Medicaid, and this will ensure no payment issues upon placement for such services as Psychiatric, Case Management, Therapy, etc. Beacon will expect payment for those services authorized and indicated by the CMH representative signature on the above said form.

If you have any questions, you can also email our referral department at referrals@beaconspecialized.org or you may contact our corporate office by calling (269) 585-0602 and speaking to Natasha Hooley, Executive Director of Admissions.

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 note that Beacon Specialized Living is HCBS compliant. To ensure that we remain compliant, any restrictions to food, community access or other items adults would normally have in their own home must be indicated in a behavior plan. *****

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Service Authorization Form

Who is requesting services:

- ☐ Manager
- ☐ Nurse
- ☐ Clinician
- ☐ Intake

Services requested:

- ☐ Therapy
- ☐ Enhanced Staffing/One-on-One
- ☐ Transportation
- ☐ Behavior Plan
- ☐ Behavior Plan Monitoring Case
- ☐ Management Psychiatric—Med
- ☐ Review Psychiatric—Psych
- ☐ Evaluation

Costs related to service: _____

Communication of requests:

Date	Initials	Action	Comments

Beacon representative: _____ Date:_____
CMH Representative: _____ Date:_____
Guardian:_____ Date: _____
(if applicable)

BSLS does not bill Medicaid/Medicare. Therefore, your signature represents authorization of said services and in turn BSLS will expect payment from your agency, regardless of whether or not you are the "payor of last resort".

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Please answer the following questions related to the consumer:

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ SSN: _____ Gender: _____

Marital Status: _____ Race: _____

Client Reference #: _____ Height: _____ Weight: _____

Veteran: ☐Yes ☐No Is there a surviving spouse/child of veteran? ☐Yes ☐No

Primary Language: _____ Date of Referral: _____

COVID-19 Vaccination Status:
☐ Fully vaccinated ☐ Partially vaccinated ☐ Unvaccinated

Court Order:
☐Yes ☐No Type (If applicable): _____
Expires: _____

County In Which Order Was Issued: _____

Is there a specific home to which you are referring the individual?
If yes, which home(s) or geographic areas is the individual interested in:

_____
_____
_____
_____

Are there any areas of the state to which you would prefer the individual not be referred (ie: Eastside, certain towns, Upper Peninsula, etc.)? ☐ Yes ☐ No

_____
_____
_____
_____

Funeral Provisions & Preferences: _____

Religious Preference: _____

Current Address: _____ City, St, Zip _____

Phone number *(CELL)*: _____ Phone number *(HOME)*: _____

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REFERRAL SOURCE CONTACT

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* _____

PHYSICIAN

Name: _____ Email: _____

Address: _____ City, St, Zip: _____

Phone: *(CELL)* _____ *(FAX):* _____

PSYCHIATRIST

Name: _____ Email: _____

Address: _____ City, St, Zip: _

Phone: *(CELL)* _____ *(FAX):* _____

RESPONSIBLE AGENCY

Name: _____ Email: _____

Address: _____ City, St, Zip: _____

Phone: *(CELL)* _____ *(FAX):* _____

CASE MANAGER

Name: _____ Email: _____

Address: _____ City, St, Zip: _

Phone: *(CELL)* _____ *FAX):* _____

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EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* ___

NEXT OF KIN

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* ___

GUARDIAN

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* __

PAYEE/CONSERVATOR

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* __

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Diagnosis:

Diet:

Allergies: _____

Contracted Services:

☐ Case Management
☐ Group Counseling
☐ Enhanced Staffing:
(# of hours) _____

☐ Behavior Treatment Plan
☐ Individual Counseling
☐ Behavior Plan Monitoring:
_____

☐ Psychiatric Services
☐ Dialectical Behavior Therapy

Medications: (current medications. Please list below or attach a list)

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ADVANCED DIRECTIVES

Does individual have an advanced directive? ☐ Yes ☐ No

If yes, attach a copy.

Is there a psychiatric advanced directive? ☐ Yes ☐ No
If yes, attach a copy.

Will Beacon staff need to assist individual in applying for benefits? ☐ Yes ☐ No

Does the individual currently have Medicaid and/or Social Security benefits? If yes, please include policy number and types of policies. ☐ Yes ☐ No

Policy Number: _____ Types of Policies: _____

MEDICAID: Number/Plan: _____

Spend down? If yes, amount: _____ ☐ Yes ☐ No

MEDICARE: Part A: _____

Part B: _____

Part C: _____

Part D: _____

Medicare Advantage Plan: _____

Private Insurance (Name of Plan & ID Number): _____

Does individual have current insurance cards (not copies)? ☐ Yes ☐ No
Please attach copy if possible.

If no, can physical cards be requested? ☐ Yes ☐ No

Does individual receive Supplemental Security Income? ☐ Yes ☐ No

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

Does individual have a valid state ID? ☐ Yes ☐ No

Is individual under 26 years of age? ☐ Yes ☐ No

If yes, would they be interested in the School Program? ☐ Yes ☐ No

Current Individualized Education Program? ☐ Yes ☐ No

Please attach copy or list last known school attended: _____

Is individual a diabetic? ☐ Yes ☐ No

If yes, does individual have a guardian? ☐ Yes ☐ No

If applicable, does individual have doctor's permission to administer their own insulin? ☐ Yes ☐ No

Are there any medication compliance issues? ☐ Yes ☐ No

Please explain:

_____

_____

_____

_____

Is the individual a suicide risk? ☐ Yes ☐ No
Please explain:

_____

_____

_____

_____

Is the individual a threat or danger to others and/or do they have thoughts to harm others? Please explain. ☐ Yes ☐ No

_____

_____

_____

_____

Does this individual have a history of sexual inappropriateness or sexually assaultive behaviors? Please explain: ☐ Yes ☐ No

Has the individual had any recent threatening behavior? Please explain: ☐ Yes ☐ No

Are there any high-risk behaviors (ie: cutting, head banging, elopement, self-injurious behavior, poor or dangerous relationships, risk taking, etc.)? Please explain: ☐ Yes ☐ No

Does the individual appear to be compatible with other individuals in the home? Are there any foreseeable problems? Has the individual agreed to having a roommate as required by HCBS if applicable? Please explain: ☐ Yes ☐ No

Does the client need to be registered with police referencing public indecency and/or a sex offense? If so, how often do they need to register? Please describe the nature and date of the offense. ☐ Yes ☐ No

Has the individual agreed to live in a Beacon home (as required by HCBS)? Please explain: ☐ Yes ☐ No

Does the individual require continuous nursing care? Please explain: ☐ Yes ☐ No

Does the individual require isolation for medical purposes? Please explain: ☐ Yes ☐ No

Does the individual have any medical diagnosis that require a specialist care or that would make them potentially high-risk and require extra briefing of the staff? Please explain: ☐ Yes ☐ No

Does the individual require seclusion or a restraint? Please explain: ☐ Yes ☐ No

Does the individual want to participate in any social and/or programmed activities? ie: school, workshop/job, religious practices, etc. ☐ Yes ☐ No
Please explain:

What amount of personal care does the individual need? Please write in the amount of personal care the referral source indicates the individual needs with an explanation of the type.
Please explain:

What amount of supervision does this individual need? ie: Does the client need one-on-one supervision in the house or in the community? Please be as detailed as possible as to how many hours if one-on-one is being requested. (Please note if the client has restricted community access, this must be in a Behavior Plan upon arrival at the facility.) Please explain:

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 available to meet this individual's needs? ie: nurse, social worker, therapist, gentle teaching, etc.

What kind of physical accommodations does the home need to be able to meet the individual's needs? ie: alarms, fence, staffing levels, handicap accessibility, etc.

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Please attach the following required documents if available:

- Guardianship Paperwork
- Health Care Appraisal
- Current Psychiatric Evaluation
- Any Psychological Assessments
- Upcoming Medical/Dental Appointments
- Clinical Certifications
- Treatment Orders
- Current Medication List/Current Prescriptions
- 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. Additionally, if individual has behaviors that Beacon determines require a Behavior Plan to keep them safe, we may require this to be in place upon the date of admission.

COMMUNITY ACCESS

Will this individual have independent community access at the time of intake? ☐ Yes ☐ No

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

_____

_____

_____

_____

If the client does not have community access or has limitations on community access, they must arrive with a plan clearly outlining the restriction. Otherwise they are presumed to have full unrestricted access. Marking "no" on the referral is not enough for Beacon to restrict an individual's freedom of movement.

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.