REFERRAL DOCUMENTATION CHECKLIST

Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD)

Individual's Name:	
TABS ID:	
Medicaid CIN:	
Name of Referrer:	
Referrer Phone Number:	

OPWDD Regional Office will be responsible for conducting a review of the referral specific to confirming the following:

1. **Confirmation of CSIDD Enrollment Eligibility (must meet all):**
   - ☐ Individual meets OPWDD eligibility, and
   - ☐ Individual is enrolled in Medicaid, and
   - ☐ Individual must be 6 years of age and older, and
   - ☐ Individual has significant behavioral and/or Mental Health needs
2. **Referral screening form, which includes, at minimum information regarding:**
   - ☐ General demographics, current diagnosis, caregiver and living situation, and reason for referral, including current frequency and intensity of symptoms/concerns, interventions that have been attempted and their effectiveness, as well as benefits expected from CSIDD enrollment
3. **Release of Information**
   - ☐ All required consents are signed
4. **BPIR Administration as needed (for re-admissions within a year of discharge)**
   - ☐ Initial BPIR Tier: ___________

Date of Referral Checklist Submission to Regional Office:	
CSIDD Agency Completing Checklist:	
Name of CSIDD Staff Member Submitting Checklist:	
Phone Number of CSIDD Staff Member:	

Regional Office Eligibility Determination

- ☐ Individual is authorized for CSIDD services; **Please enter service into TABS**
- ☐ Individual does not qualify for CSIDD services; Explain:___________________________

Date of Determination:	
Name of Regional Office Approver:	
Signature of Regional Office Approver:	