| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-02500 (12/2020) |  | **STATE OF WISCONSIN** |
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| **FACILITY REFERRAL TO ADRC/TRIBAL ADRS FOR PUBLICLY FUNDED LONG-TERM CARE** |
| Completion of this form is voluntary. However, no referral to the aging and disability resource center (ADRC) or tribal aging and disability resource specialist (Tribal ADRS) will be processed without the completed form. All information must be complete and accurate. This form should be used for referral for individuals currently located at:1. The Department of Correction’s (DOC) institutions and centers (see <https://doc.wi.gov/Documents/OffenderInformation/AdultInstitutions/DAIFacilities.pdf>).
2. The Department of Health Services (DHS) secure treatment centers of Sand Ridge Secure Treatment Center or Wisconsin Resource Center.
3. The DHS’s Institutes for Mental Disease (IMD) Mendota or Winnebago Mental Health Institutes.
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| Section 1 – Referral Agent |
| **Facility Name:** Name of the facility where the individual is currently located.**Date of Referral:** Date the form is being submitted to the ADRC/Tribal ADRS. **Name of Referral Agent:** Name of facility staff making referral to the ADRC/Tribal ADRS for the individual.**Phone:** Phone number of the referral agent.**Email:** Email address of the referral agent.**Name of Community Case Manager (if known):** A professional, such as a probation and parole agent, who collaborates with a client and other stakeholders/supports associated with the client to coordinate services, treatment, recovery, and reintegration into the community.**Phone:** Phone number of the community case manager.**Email:** Email address of the community case manager. |
| Section 2 – Individual Information |
| **Individual Name:** Name of the individual being referred to the ADRC/Tribal ADRS. **Date of Birth:** Individuals date of birth**County of Residence/Responsibility:**1. **Wis. Stat. § 49.001(6):** “Residence" means the voluntary concurrence of physical presence with intent to remain in a place of fixed habitation. Physical presence shall be prima facie evidence of intent to remain. 2. **Wis. Stat. § 49.001(8):** "Voluntary” means according to an individual’s free choice, if competent or by choice of his or her guardian if the individual is adjudicated incompetent. 3. **Wis. Stat. § 51.01(14):** “Residence” has the meaning given under s. 49.001 (6). **The following four criteria must occur simultaneously**. If any one of the four criteria does not apply to a person, legal residency is not established. * The person is physically present in the state/county;
* The persons physical presence is voluntary;
* The person has an intent to remain in the state/county; and
* The person is living in a place of fixed habitation.

**How was the county of residence/responsibility determined:** The county of residence/responsibly is not necessarily the county in which the facility is located or the county in which the offense took place. If the county of responsibility is unknown, the facility should contact the assigned human services area coordinator in area administration to assist in residency determination before contacting the appropriate ADRC or tribe. Contact information for area administration can be found at <https://www.dhs.wisconsin.gov/areaadmin/index.htm>.The facility should document how residency/responsibility was determined.Clients on Supervised Release are typically ordered to be placed in their county of residence. (Wis. Stat. § 980.105(1m). The designated ADRC/tribal ADRS in the client’s county of residence is required to conduct the Long Term Care Functional Screen regardless of the county in which the individual is ordered to reside. **Anticipated Discharge/Release Date:** Date the individual will be discharged from the facility. **Established Guardianship:** Indicate if the individual has guardianship of estate, person or both established. Include county in which guardianship was determined. **Activated Power of Attorney (POA) for Health Care:** Indicate if the individual has an activated power of attorney for health care.**Activated Power of Attorney (POA) for Finance:** Indicate if the individual has an activated power of attorney for finance.**Name-Guardian/POA:** Name of individual’s guardian or POA.**Phone:** Phone number of guardian or POA**Best Time to Contact:** Best time for the ADRC to reach the guardian/POA.**Medicaid Eligibility Established:** Indicate Medicaid eligibility status for the individual. If an application for financial eligibility has not been submitted, please indicate when facility will apply. If eligibility is pending, include the date of application. If MA eligibility is suspended, include the date it will reopen. Date to open for suspended incarcerated members will be the release date. An individual must meet financial eligibly requirements for enrollment into a long-term care program. A referral may be sent prior to an MA application being submitted or eligibility being determined. **Medicare or Other Insurance:** Indicate if the individual has Medicare or other insurance. **Verified Medical/Psychological Diagnoses:** List all diagnoses (medical or psychological) the individual currently has. Diagnoses must be verified by a medical professional. **Functional Limitations as they relate to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)**ADLs are bathing, dressing, eating, mobility, toileting, and transferring.IADLs are meal preparation, medication administration and medication management, money management, laundry and/or chores, telephone and transportation. Functional limitations are the individual’s need for assistance from another person to complete an ADL or IADL due to a physical, cognitive or memory loss impairment. For example, an individual requires verbal cues to bathe due to their dementia diagnosis. **Other Pertinent Information:** Include any other information that may be helpful to the ADRC/tribal ADRS such as durable medical equipment used, special conditions upon release, etc. |
| Completion of this form is voluntary. However, no referral to the aging and disability resource center (ADRC) or tribal ADRS can be processed without the completed form. All information entered must be complete and accurate. Department of Corrections facility staff and the Department of Health Services facility staff complete and submit this form to the appropriate ADRC. Please include a release of information that allows for the exchange of information between the facility and ADRC or Tribal ADRS. |
| Section 1 – Referral Agent |
| Facility Name | Date of Referral |
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| Name of Referral Agent | Phone | Email |
|       |       |       |
| Name of Community Case Manager (if known) | Phone | Email |
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| Section 2 – Individual Information |
| Individual Name (First, MI, Last) | Date of Birth |
|       |       |
| County of Residence/Responsibility |
|       |
| How was county of responsibility determined? |
|       |
| Anticipated Discharge/Release Date | Guardianship | County of Guardianship |
|       | [ ]  Yes [ ]  No |       |
| Activated POA for Health Care | Activated POA for Finance |
| [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Name – Guardian/POA | Phone | Best Time to Contact |
|       |       |       |
| Medicaid Eligibility Established | Medicare or Other Insurance |
| [ ]  No: Anticipated Date of Application       [ ]  Pending: Date of Application       [ ]  Suspended: Date to Open       | [ ]  Yes [ ]  No |
| Previously Enrolled in a Long Term Care Program | Program | MCO or ICA |
| [ ]  Yes [ ]  No [ ]  Unknown | [ ]  Family Care [ ]  PACE[ ]  Partnership [ ]  IRIS |       |
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| Verified Medical/Psychological Diagnoses, including date of diagnosis and diagnosing physician and facility. |
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| Functional Limitations as they Relate to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs): |
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| Other Pertinent Information: |
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