**COMMUNITY OPTIONS VISIT FORM**

Last Name of Resident:       First Name of Resident:

Name of Guardian/Auth. Rep/Family Member Present:

Name of COS:

Name of Intermediate Care Facility:

Name of QIDP:

Date of Initial Phone Contact with the Resident/Guardian/Auth Rep:

Date of Face to Face Meeting:

Start time of Meeting:       End time of Meeting:

**If Face to Face Meeting did not occur or was not timely following initial phone contact, please explain why:**

[ ] Trouble contacting ICF/ resident [ ] Resident requested to reschedule [ ] Guardian refusal [ ] Resident refused visit

[ ] NC/NS

[ ] Other (please describe):

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| **Section A: Individual’s Meeting Summary- based on the individual’s responses (or family/guardian)** **Please complete Section A to document the Face to Face meeting or Phone Contact with resident** |
| **Needs and Preferences** | **Referrals and Resources** |
| **Areas of consideration/discussion regarding the needs and preferences voiced by the Resident:**[ ]  **HOUSING** Do you want to live with other people or do you want to live alone?      [ ]  **CARE PROVIDERS**How much influence do you want to have over who provides your care?      Do you have someone who could help you with what you need if a provider called off?     Do you need to have someone available to help you immediately?     [ ]  **MONEY**Do you want to handle your money on your own or is it okay if someone else takes care of your money?     Do you want to pay for all of your own bills like rent and electric, and for food or do you want to know that these things are already paid for each month?     [ ]  **COMMUNITY/** **EMPLOYMENT/SOCIAL**Do you want to choose your Day Program/Work or do you want someone to choose this for you?     Do you like to have someone help you plan your day or do you like to plan your day yourself?     [ ]  **SUPPORTS**Do you have family or friends that take you where you want to go or do you rely mostly on others to arrange your transportation?      | **The COS provided the Resident with the following information:**[ ] ICF/Waiver Comparison Handout[ ] What is a Waiver handout[ ] HOME Choice Information[ ] What is an SSA Handout [ ] What is a QIDP Handout[ ] HCBS Handout[ ]  Other      [ ]  **The Resident IS NOT interested in a HCBS Waiver at this time.** [ ]  **The resident IS interested in a HCBS Waiver.**[ ]  **The Resident MAY BE interested in a HCBS Waiver but requests additional information.****[ ]  Individual already slated for a Conversion Waiver**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***The Resident/Guardian/Auth. Rep requested the following referrals:**[ ]  **Peer-to-Peer Counseling. Referral made to:**     [ ]  **Referral to Home Choice:** [ ]  **County Board of DD:**      [ ]  **Other:**[ ]  **Release of information signed (if needed)** |

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| **Section B: Summary of Conversation with Resident/Guardian and/or QIDP:**  |
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| **If Face to Face meeting with resident has occurred, please have Resident/Guardian/Auth. Rep read and sign the following statement:**My signature verifies I met with a Community Options Specialist who shared information regarding Home and Community Based Waivers, the roles of County Board of Developmental Disabilities and the Service and Support Administrator, and features and types of services available in an ICF, as well as resources about my community that might help me return to community living.I understand I will need to address any barriers that may exist and agree to work with my County Board of Developmental Disabilities as well as Qualified Intellectual Disability Professional for further information and referral related to Waiver services and community living.**Printed Name of Resident:**  Resident/Guardian/Auth. Rep. Signature: ­­­­­­­­­­       Date:        :  |