Vaya Health

Non-Medicaid Residential Services Referral Profile

NON-MEDICAID RESIDENTIAL SERVICES:

Required submission checklist for referral process

- ☐ **Applicant's Non-Medicaid Residential Services Referral Profile**
  (Note: Vaya Health's Non-Medicaid Residential Referral Profile (this document) is available online at www.vayahealth.com.

- ☐ **Applicant's most recent psychological evaluation ***
  Evaluations must have been completed within the past five years. A full-scale IQ score and Adaptive Composite Score are required for applicants with an intellectual and/or developmental disability (IDD).

- ☐ **Applicant's most recent Person-Centered Plan (PCP) ***
  For applicants with an IDD diagnosis, an N.C. Support Needs Assessment Profile (NC-SNAP), Supports Intensity Scale (SIS) or Level of Care (LOC) assessment is required. NC-SNAP, SIS and LOC assessments must have been completed in the past year.

- ☐ **Provider agency application (submitted to provider agency only)**

- ☐ **Guardianship papers**

* The member's psychological evaluation and PCP must be submitted to NonMedicaidResidential@vayahealth.com for referral to the Non-Medicaid Residential Services waiting list.

SUBMISSION INSTRUCTIONS

Documentation may be submitted in one of three ways:

1. Upload documentation into AlphaMCS.
2. Submit via secure email to NonMedicaidResidential@vayahealth.com.
3. Fax documentation to Vaya at 828-452-3473.

PLEASE NOTE: These documents should be submitted to the IDD housing specialist for review of completeness of the above documents and information. Upon receipt of all necessary documents and information, Vaya's Utilization Management Department will determine eligibility. **Determination of eligibility does not mean that funding is readily available.** Non-Medicaid services are not an entitlement, and availability is based on funding Vaya receives from the state. **There is no entitlement to housing funds through Vaya, other than the Transitions to Community Living Initiative.**

NON-MEDICAID RESIDENTIAL REFERRAL PROFILE

I. MEMBER INFORMATION

Member: _____ **Vaya MRN:** _____ **Date of birth:** _____

Date of assessment: _____ **Home county:** _____

Current services: _____

Member preference regarding county of residency: _____

Level of service requested: _____

Date member first made application for this level of service: _____

II. REFERRAL SOURCE

Name: _____ **Agency:** _____

Relationship to member: _____

Guardianship information: _____

Telephone: _____ **Email**: _____

III. FUNDING SOURCE

Medicare: ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No

SSI: ☐ Yes ☐ No

Other: ☐ Yes ☐ No **Describe:** _____

IV. MEMBER NEEDS ASSESSMENT

A. MEDICAL NEEDS

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

B. MENTAL HEALTH NEEDS

Mental health needs include current services, past traumas, etc.

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

C. BEHAVIORAL NEEDS

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

D. ACTIVITIES OF DAILY LIVING NEEDS

Activities of daily living needs may include assistance with eating, drinking, bathing, dressing, toileting, etc.

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

E. SUPERVISION NEEDS

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

F. PHYSICAL ACCOMMODATIONS

Physical accommodations include assistance with mobility, adaptive equipment, independent living skills, etc.

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

G. DAY PLACEMENT/EMPLOYMENT NEEDS

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

H. MEDICATION NEEDS

List any and all medications member is prescribed and include dosage amount and frequency:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

I. OTHER NEEDS AND/OR COMMENTS

Describe member's needs:

Does member require additional accommodations and/or additional staff support in this area? ☐ Yes ☐ No

If yes, explain:

IV. SIGNATURES

_____	_____	_____
Member/guardian printed name	**Signature**	**Date**
_____	_____	_____
Person making referral (if not member/guardian)	**Signature**	**Date**