TN Division of TennCare

Employment and Community First CHOICES
Referral List Contact Form

Demographic Information

Name:	SSN:	DOB:

Address:	Telephone #: Alternate #:
Do you live ❑ Alone ❑ With natural or adoptive family ❑ With someone else, who?	Do you plan to stay where you are living? ❑ Yes ❑ No, where do you plan to live?

Designee/ Representative

Name:	Relationship:
Address:	Telephone #: Alternate #:

Contact information

Date of contact	❑ Telephonic ❑ Face to Face, location________________________________
❑ Unable to contact	1st attempt 2nd attempt 3rd attempt

Submitter information

Name/ Credentials:	Submitting Agency
Telephone #	Email Address

Target Population

Do you have an ❑Intellectual Disability(ID)* ❑ Developmental Disability(DD)** ❑Neither

***ID**: This means you have an IQ of 70 or below. This makes it harder for you to do at least two of these things: learn, communicate, take care of yourself, stay safe and healthy, make decisions, work, live independently, do things in the community, use community services and interact with other people. These problems must have started **before the age of 18**.

DD: This means you have physical or mental health problems that started **before the age of 22 and are expected to continue. Because of those problems, you need help to do at least three of these things: learn, communicate, walk, take care of yourself, make decisions, work and live independently.

Priority Groups

Question			
Do you have a job? ❑ No ❑ Yes, Employer:			
Do you need services and supports (job coach, transportation, help getting dressed) to help you keep your job?		❑ Yes	❑ No
Do you have a job you could start if you could get services and supports to help you with your job?		❑ Yes	❑ No
Have you recently lost a job and need services and supports to help you get or keep a new job?		❑ Yes	❑ No
If you are not working now, have you ever had a job before?	❑ Yes	❑ No	❑ N/A
Do you want to work?		❑ Yes	❑ No
If you aren't sure you want to work, are you willing to explore the *possibility* of working?	❑ Yes	❑ No	❑ N/A
Are you in school now? ❑ No ❑ Yes, Are you about to leave school and need help getting a job?		❑ Yes	❑ No
If you're age 62 or older and don't want to work, do you need help to live and do things in the community? ❑ Yes ❑ No ☐N/A—want to work OR not age 62 or older			
If you're age 55 or older, do your health problems or disabilities make it hard for you to work, even if you have supports to help you work? ❑ Yes ❑ No ☐N/A—not age 55 or older or don't have health problems or disabilities that would make it hard to work			
Do you need help to live and do things in the community?		❑ Yes	❑ No

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Reserve Capacity	
Do you need help to move out of a long term care facility like a NF or an ICF/ IID?	❑ Yes ❑ No
Are you getting ready to leave the hospital and need nursing home care if you can't get support at home?	❑ Yes ❑ No
Do you need support to leave a mental health hospital or jail?	❑ Yes ❑ No
Do you need to find new living arrangements because of abuse, neglect, or exploitation?	❑ Yes ❑ No
Have you recently lost the place you lived in **and** the supports you were getting there?	❑ Yes ❑ No
If you can't go back there, do you have anywhere else to go?	❑ Yes ❑ No
Are you age 21 or older, have complex health problems and need so much nursing care that it would be hard for you to work?	❑ Yes ❑ No
Are you turning age 21 and can't get as much nursing care because your benefits are changing?	❑ Yes ❑ No
If you don't get help right away, will you need care that would cost more, like care in a nursing home?	❑ Yes ❑ No
Do you have behaviors that physically hurt you or others, or that place you or others at serious risk of harm? (This could be things like physically hurting yourself or someone else, eating non-edible substances, or acting out sexually)	❑ Yes ❑ No
Are your family members or caregivers having a hard time meeting your needs?	❑ Yes ❑ No
Do you need supports right away to keep your current living arrangement?	❑ Yes ❑ No
Tell us about your caregiver	
Do you have someone who helps provide the support you need?	❑ Yes ❑ No
If **YES,** tell us more about who provides most of your care, this is your Primary Caregiver.	
Name: Relationship: DOB:	Age:
Is your primary caregiver recently deceased?	❑ Yes ❑ No
If **YES,** do you have another caregiver to provide most of the help you need?	❑ Yes ❑ No
Is your primary caregiver permanently disabled and can't care for you anymore?	❑ Yes ❑ No
If **YES,** do you have another caregiver to provide most of the help you need?	❑ Yes ❑ No
Is your primary caregiver's health poor and getting worse?	❑ Yes ❑ No
If **YES,** do you need help to move to a different place before they aren't able to support you anymore?	❑ Yes ❑ No
Next Steps	
If you qualify for services **and** we have a slot for you, do you want to see if you can receive services **now**?	❑ Yes ❑ No
If YES complete section A below. If NO, complete section B below	
Section A	
Has an intake visit been completed? ❑ Yes ❑ No If **NO**, assist with completion of the online self-referral indicate "referral" below and complete the case management contact. If **YES,** indicate "update and manage" below and complete the case management contact.	
Section B	
If **NO,** would you like to remain on the referral list in case you want services in the future? ❑ Yes ❑ No If **YES,** indicate "defer, update and remain on list" below and complete the case management contact. If **NO**, complete the "request to be taken off the referral list" form, indicate "remove from list" below and complete ECF Referral List contact.	
Case Management assistance needed:	
Completing the ECF Referral List Contact	
❑ Referral Has an ***Intake Outcome Form*** been completed as part of this visit? ❑ Yes ❑ No	
❑ Update and Manage Is there a change in Priority Categories or Reserve Capacity groups the person may qualify in? ❑ Yes ❑ No If yes, has an ***Intake Outcome Form*** been completed as part of this visit? ❑ Yes ❑ No	
❑ Defer, update and remain on the list	
❑ Remove from the referral list **NOTE: Requires completed and signed Request Form**	
I certify that I have completed this ECF Referral list contact with the individual or the designee/ representative for the individual named on this form. I have reviewed all of the required educational materials and have answered all questions to the best of my ability. I have marked all responses based on information provided by the individual or their designee/ representative. I further certify that I have completed all documents required to process the outcome desired by the individual or their designee/ representative.	
Signature/ Credentials of person completing this form:	Date: