Optimae LIFESERVICES
At your side. On your side.

APPLICATION FOR INTENSIVE RESIDENTIAL SERVICES (IRS)

A complete referral is necessary and must include the following items and each question within the application answered fully. Referrals that are missing the requirements, as outlined below, will not be considered a complete referral.

1. Application for Services

2. Comprehensive Assessment and Social History (CASH). CASH needs to be the most recent social history and assessment completed for the applicant.

3. Diagnosis Records: Must include evidence of diagnoses of a Severe & Persistent Mental Illness (SPMI) or multi-occurring conditions with the ICD 10 code(s) included.

4. Authorization showing a rate sufficient to support the needs of the applicant, as approved by the applicant's funder. Referring entity should work with applicant's funder to secure the necessary rate.

5. Standardized Functional Assessment and screening for multi-occurring conditions within 60 days or less prior to this IRS application:

   (a) Habilitation – Comprehensive Assessment & Social History (CASH) and LOCUS

   (b) Intellectual Disability Waiver – InterRAI-ID

Upon receiving a complete referral, a representative from our team will follow-up with the referral entity to discuss next steps.

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APPLICATION FOR OPTIMAE SERVICES

Optimae supports the basic fundamental rights of all people. Your right to participate in the identification of service needs and planning and choosing how to meet those needs drives Optimae as a human service agency. Optimae LifeServices does not discriminate in the provision of services to an individual (a) because the individual is unable to pay, (b) because payment for those services would be made under Medicare, Medicaid or Hawk I (CHIP) or (c) based upon the individual's race, color, gender identity or expression, national origin, disability, religion, age, socioeconomic status, sex or sexual orientation (or any other characteristic protected by law). Optimae does not administer physical, manual, or chemical restraints. For you to consider Optimae as a potential service provider, please provide the following information:

Legal Name: Chosen Name: SSN (if known):

Date of Birth: Telephone:

Current Address:

Guardian? ☐ Yes ☐ No If yes, guardian name and contact information:

Medicaid #: Medicaid Renewal Month: MEPD: ☐ Yes ☐ No

Approved for Funding? ☐ Yes ☐ No

☐ MCO ☐ FFS / IME ☐ Private Pay ☐ MH Region: ☐ DAP AURA MRN#:

MCO: MCO ID #:

☐ ID Waiver (InterRAI Score:) ☐ BI Waiver ☐ CSS

☐ Habilitation (LOCUS Score:) (Indicate Tier ☐ UA ☐ UB ☐ UC ☐ UD ☐ U8 ☐ U9 ☐ Unknown)

Mental Health Diagnoses:

Physical Health Diagnoses:

Primary Language: ☐ English ☐ Spanish ☐ Other: Interpreter Needed? ☐ Yes ☐ No

Legal Gender: Chosen Gender Identity/Expression:

Referral Source: Referral Telephone:

Referral Source Email Address:

Are you currently or have you recently received services? Describe service(s) and number of hours/week received:

Contact(s) for prior psychiatric evaluations, psychological tests, social histories, or other assessments:

Type of services: ☐ SCL Site Home (complete 2nd page) ☐ Youth Transitional Site Home (complete 2nd page)
☐ Day Hab/CIP ☐ CSS ☐ Supported Employment ☐ Respite ☐ RCF ☐ SCL Hourly ☐ RBSCL ☐ Other:

Please attach any supporting information (e.g., social history, assessments, diagnosis, service documentation, legal docs.).

_____ ☐ Individual ☐ Referral Source
Signature of Applicant Date

_____
Optimae Designee Signature Job Title Date

Application for Optimae Services

Additional Information

Only fill out if seeking SCL Site Home or Youth Transitional Site Home placement

Disclaimer: *This information is used to help determine compatibility with potential openings available.*

Specific Needs of the Customer:

Housemates Preference: ☐ Co-Ed ☐ Female Only ☐ Male Only

Location Preference:
Willing to relocate within Iowa: ☐ Yes ☐ No

Does the customer need wheelchair accessibility? ☐ Yes ☐ No

Is the customer able to independently navigate stairs? ☐ Yes ☐ No

Does the customer exhibit current behavioral concerns? ☐ Yes ☐ No
If yes, explain:

Is the customer in school? ☐ Yes ☐ No

If Yes, name of school:

Does the customer have an IEP? ☐ Yes ☐ No

If Yes, what kind of IEP ☐ initial ☐ annual ☐ interim

Most recent grade completed: Does the customer have a 504 plan? ☐ Yes ☐ No

Additional services needed: ☐ BHIS ☐ IPR ☐ Behavioral Health ☐ Occupational Therapy ☐ Physical Therapy ☐ Home Health (18 and older) ☐ Other:

Is the customer on the Sex Offender Registry? ☐ Yes ☐ No
If yes, are they required to abide by the 2000-foot rule? ☐ Yes ☐ No

Does the customer require overnight supervision? ☐ Yes ☐ No

Does the customer have monthly income such as: ☐ Social Security Benefits ☐ Earned Income ☐ Other:
In the process of applying for SSA benefits ☐ Yes ☐ No

Does the customer have a payee? ☐ Yes ☐ No Payee contact Information:

Does the customer require an Emotional Support or Service Animal? ☐ Yes ☐ No
Type of Animal:

How much non-supervised time does the customer use? ☐ 0 hrs ☐ 1-2 hrs ☐ 2-4 hrs ☐ 4-8 hrs ☐ 8+hrs

Additional Information:

Please return this completed form to TRRReferrals@optimae.com