Medically Involved Children's Program Referral Form

Children's Intensive In-Home Services (CIIS)

Today's Date:____________________________

Child's Name: ___________________________ DOB:_____________

Social Security Number:_____________________________________

Parent(s) Names:____

Address:____

City:__________________________ State:_____ Zip Code:_________

Phone:____________________ Work:___________ Cell:___________

Language spoken in the home: ___English ___________Other

Current Services Received

☐ SSI
☐ Private Insurance - _____________________________________
☐ Medicaid – Prime number:___________________
☐ CM Only (DD48)
☐ Personal Care 20
If not used please explain:_________________________________
☐ Family Support Annual plan amount:___________ *
☐ STD Annual plan amount:___________ *
☐ LTD Annual plan amount:___________ *
*Please attach a copy of the current plan(s) to your referral
☐ Other ____

General Referral Information

Does the family know they are being referred to CIIS? ☐ Yes ☐ No

The child currently resides:
☐ In the family home ☐ In a Nursing Facility
☐ Foster Care ☐ Other_____________________________

Is the child currently DD eligible? ☐Yes ☐No
*If "Yes", include a copy of the current DD eligibility statement
County Name:________________________
CDDP case manager:__________________ Phone:_______________

Is the child a U.S. Citizen? ☐ Yes ☐ No

Presenting Medical Issues and Care Needs

Primary Physician:________________________ Phone:____________

Diagnosis:____

____

Please provide a description of conditions that apply:

Feeding:____

____

Toileting/Incontinence:_______________________________________

____

Communication:____

____

Therapy Services:____

____

Equipment Used in Home: ______________________________________

____

Please give a short description of child's disability and support needs:

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Referral Source Information
This referral is made by: ☐ Parent or family member ____________ ☐ Nursing Facility _____________________ ☐ SPD/DSO/AAA _____________________Branch #_________ ☐ CDDP: ______________________________ Referral contact name/phone: _________________________________ ____

For CIIS use Only
Database has been cross referenced and updated with the following information:
Child previously enrolled in CIIS services ☐ Yes, dates______________☐ No
Citizenship confirmed with CMG (attach copy) ☐ Complete
Referral packet completion date: ___________________

Please mail or fax a copy of this referral form and the following documentation:

- ☐ A current DD eligibility statement, when applicable
- ☐ Copies of any family support or crisis diversion plans
- ☐ Copies of any recent medical/therapeutic assessments that will help us better understand the child's complex care needs

Mail or fax to:

CIIS Referral Coordinator
Seniors and People with Disabilities
600 NW 14th Ave, Suite 100
Portland, OR 97209
Fax: (971) 673-2971
Phone: (971) 673-2981