

Heritage Christian Services
Fiscal Intermediary Referral Form



*Rochester/Finger Lakes area: Please send completed referrals to SDReferrals@heritagechristianservices.org

*Buffalo Area: Please send completed referrals to WNYSDReferrals@heritagechristianservices.org

Name of person being referred for Fiscal Intermediary Services: _____

Sex: _____

Race: _____

Ethnicity: _____

Address (include town and Zip): _____

County: _____

Phone Number (10 digit): _____

Email*: _____

Date of Birth: _____

Primary Language: _____ **Interpreter needed?** ☐ Yes / ☐ No

Primary Developmental Disability: _____

Advocate's #1 Name: _____

Relationship to person seeking services? _____

Legal Guardian (supply guardian paperwork)? ☐ Yes / ☐ No

Primary Language: _____ **Interpreter needed?** ☐ Yes / ☐ No

Advocate's Phone Number (10 digit): _____

Advocate's Email*: _____

Advocate's Address (include town and zip): _____

Advocate's #2 Name: _____

Relationship to person seeking services? _____

Legal Guardian (supply guardian paperwork)? ☐ Yes / ☐ No

Primary Language: _____ **Interpreter needed?** ☐ Yes / ☐ No

Revised 02/08/2023

*An active email is required for eVer0 and Self-Directed Services with Heritage Christian Services

Advocate's Phone Number (10 digit): _____

Advocate's Email*: _____

Advocate's Address (include town and zip): _____

Care Coordinator Name: _____

Care Coordinator Agency: _____

Care Coordinator email: _____

Care Coordinator Phone (10 digit): _____

Care Coordinator Address: _____

Do you currently receive FI/Broker services elsewhere? ☐ Yes / ☐ No If yes, be sure to complete all 3 pages of this referral.

Heritage Christian Services no longer provides agency brokerage. All participants will need to identify a broker in order to complete FI intake.

Which Broker has been identified? _____

Broker Email: _____ Broker Phone: _____

What date did you attended the Self-Direction Information Session (REQUIRED):

Do you have a Behavior Support Plan? ☐ Yes / ☐ No

Do you use an EPI Pen, Emergency Seizure medication or have specialized Medical Needs? ☐ Yes / ☐ No

If so, please specify support needs: _____

Any additional information you would like us to know (behavior support needs, health/medical needs, history or seizures, mental health support needs, etc)? _____

Addendum adding FI/Broker to Section IV with HCS as a provider? ☐ Yes / ☐ No

*If this is a change of vendor please also see next section ([click here](#))

Revised 02/08/2023

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Care Coordinators/Managers, please ensure all applicants are aware that Self-Directing Participants with Heritage Christian Services are required to utilize our electronic platform, eVero.

The following documents must be sent with all referrals. Incomplete referrals will delay the intake process. Please submit as separate documents.

- | | |
|---|---|
| <input type="checkbox"/> Behavior Support Plan (if applicable) | <input type="checkbox"/> Most recent Life Plan |
| <input type="checkbox"/> HCBS Waiver Notice of Decision (NOD-1) | <input type="checkbox"/> Current LCED |
| <input type="checkbox"/> Eligibility letter | <input type="checkbox"/> Current DDP2 by CCO |
| <input type="checkbox"/> Current CR4 (TABS Individual Inquiry) | <input type="checkbox"/> Guardianship paperwork (if applicable) |
| <input type="checkbox"/> OPWDD Notice of Decision (NOD-9) or Self Direction Authorization Letter | |
| <input type="checkbox"/> Most recent Psychological Evaluation (completed within the last 3 years for a child under 21) | |
| <input type="checkbox"/> Proof of attendance of Self-Direction Info Session (please note this is different from the Front Door Session) | |
-

COV – Complete Only if Requesting an FI Agency Change from FI Another Agency:

Contact Information for current FI – Name: _____

Email: _____ **Phone:** _____

Contact Information for current Broker – Name: _____

Email: _____ **Phone:** _____

Please share a little about why a new FI agency is being pursued? _____

For any self-hired staff that need to be hired by HCS, please provide (or have the Broker provide) the following information:

Full Legal Name: _____

Email: _____

Phone: _____

Pay Rate: _____

Do they provide Respite or Com Hab (or both): ☐ Respite / ☐ Com Hab / ☐ Respite & Com Hab

How many hours do they work per week (average): _____

Are they a legal guardian to the person receiving services? ☐ Yes / ☐ No

Do they live with the person receiving services? ☐ Yes / ☐ No

Revised 02/08/2023

***An active email is required for eVero and Self-Directed Services with Heritage Christian Services**

Which Month does the family wish to change FI service providers (this is not a guaranteed effective date)?

For COV Budget, provide addendum switching over Self Directed services to HCS as provider: ☐ Yes / ☐ No _____

Are any of the following services included in their current Self-Directed Budget (check those that apply)

☐ Self-hired

☐ SEMP Live in Caregiver

☐ Paid Neighbor

☐ Housing Subsidy

☐ Self-Direction covered therapies

Parent/Guardian/Individual Consent to Use E-mail to Exchange Personally Identifiable Information

Parent/Guardian/Individual Name: _____

Individual's Name: _____ D.O.B.: _____

At your request, you have chosen to communicate personally identifiable information concerning your son/daughter's/your own services by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent/guardian.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Parent/Guardian/Individual Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using e-mail to communicate personally identifiable information.

Nevertheless (choose one or both options):

- I, _____, authorize the following individual Heritage employees _____; _____; _____; _____ whose e-mail address(s) is/are _____; _____; _____; _____@heritagechristianservices.org

AND/OR

- I, _____, authorize any Heritage employee whose email address ends with @heritagechristianservices.org

to communicate with me at my e-mail address, _____, concerning my son/daughter's/my own _____ services, including but not limited to communication regarding service delivery, his/her progress, and any other related matters. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

(Optional) In addition, I give permission for the employees identified above to communicate personally identifiable information concerning my son/daughter/myself with individuals that work outside of Heritage Christian Services using unencrypted e-mail. The outside individuals who I give permission for the above parties to use unencrypted e-mail to communicate with back and forth about treatment include:

- (1) _____ with the e-mail address _____
- (2) _____ with the e-mail address _____
- (3) _____ with the e-mail address _____

 Signature

 Date



Remote Service Delivery Consent Form

Remote service delivery is an option for people who receive Day Habilitation, Community Habilitation, Prevocational Services, Supported Employment, Support Broker and Respite Services.

Remote Service Delivery must meet these requirements:

- All providers must ensure your privacy.
- Remote service providers need to be able to provide services without risking your safety.
- All providers must ensure your services are provided with dignity and respect.
- Remote service delivery can only be provided if you have other ways to access your community (independently or with other waiver services).
- Remote service delivery cannot isolate you from interacting with people who do not have disabilities.
- Remote service delivery needs to be requested by you and not your service providers.
- Remote service delivery needs to be provided with HIPAA Compliant technology. This is currently available via Microsoft Teams accounts within Heritage Christian Services or your CCO.
- You should have some face to face services. Not all of your services should be remote.

I participate in the following community based activities*:

By signing below you agree to the following:

I have a location in which I can receive remote service delivery without jeopardizing my privacy.

I am aware that I can discontinue remote services at any time by informing Heritage Christian Services that I would like to transition to face-to-face service delivery.

I understand that if Heritage Christian Services finds remote service delivery is unsafe, ineffective or does not meet my needs, they will notify me and my Care Manager to arrange for a return to in-person service delivery.

I understand that if I do not provide written consent for remote service delivery twice annually, my services will be transitioned back to face-to-face service delivery.

I would like to receive the following services remotely:	Day Hab	Pre-Voc
	Respite	Com Hab
	Broker	Supported Employment

Name:

Signature:

Guardian Name (if applicable):

Guardian Signature (if applicable):

Date: