

Heritage Christian Services
Fiscal Intermediary Referral Form



*Rochester/Finger Lakes area: Please send completed referrals to FLSDReferrals@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 05/26/2026

*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 attend 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 05/26/2026

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

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.

- Behavior Support Plan (if applicable)
- HCBS Waiver Notice of Decision (NOD-1)
- Eligibility letter
- Current CR4 (TABS Individual Inquiry)
- OPWDD Notice of Decision (NOD-9) or Self Direction Authorization Letter
- Psychological Evaluation (Ideally the evaluations used to determine OPWDD eligibility + most recent Evaluation)
Proof of attendance of Self-Direction Info Session (please note this is different from the Front Door Session)
- Most recent Life Plan
- Current LCED
- Current DDP2 by CCO
- Guardianship paperwork (if applicable)

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 _____

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)

- | | |
|---|---|
| <input type="checkbox"/> Self-hired | <input type="checkbox"/> SEMP Live in Caregiver |
| <input type="checkbox"/> Paid Neighbor | <input type="checkbox"/> Housing Subsidy |
| <input type="checkbox"/> Self-Direction covered therapies | |



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:



Note from our Intake Team: This form is for individuals age 18 and older.

If you are 18 or older and would like your parents or advocates included in communications from HCS regarding your self-directed services, please include their information on this form. You may also note any information you do not want shared with them. Thank you!

Authorization for Release and Disclosure of Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Heritage Christian Services, Inc. may not release or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the release and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to Heritage Christian Services, Inc.

AUTHORIZATION SECTION

This authorization pertains to:

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

Individual's Address: _____

I hereby authorize Heritage Christian Services, Inc. to release and disclose of the following health information pertaining to the above noted individual:

for the following purpose:

I authorize the following persons to receive these disclosures of health information (please include their full names, relationship to you and contact information):

I understand that information released and disclosed pursuant to this authorization may be re-disclosed to additional parties and will no longer be protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Heritage Christian Services, Inc. I further understand that any



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such revocation does not apply to the extent that persons authorized to release or disclose my health information have already acted in reliance on this authorization.

I understand that if my circumstances change, I may need to complete another authorization. I understand that this authorization will be reviewed as needed with me and that it will automatically expire if and when I no longer receive services from Heritage Christian Services, Inc.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain services will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Print Name: _____

Signed: _____ Date: _____

Email Address: _____ Telephone: _____

If not signed by the individual, please indicate relationship:

- Parent or guardian of individual
- Beneficiary or personal representative of deceased individual
- Other (specify) _____

This form should be returned to the Privacy Officer either via email or mail as follows:

Email: Compliance@heritagechristianservices.org

Mail: Heritage Christian Services
Attention: Privacy Officer
275 Kenneth Drive, Suite 100
Rochester, NY 14623

REVOCAION SECTION

I hereby revoke this authorization.

Print Name: _____

Signed: _____ Date: _____