**Regional Support Team (RST) Referral Instructions**

* *For individuals enrolled or awarded a waiver slot, review and completion of the Virginia Informed Choice (VIC) is required prior to submission of an RST referral. The Support Coordinator/Case Manager/Training Center Designee completes the VIC and retains a signed copy of the document in the individual’s file.*  *Virginia Informed Choice completed and submitting with RST Referral*
* *The Support Coordinator/Case Manager/Training Center Designee completes the Regional Support Team Referral.*
* *Community Resource Consultant (CRC)/Community Integration Manager (CIM) consultation is required prior to an RST Referral submission.*
* *Submit VIC (if required) and RST Referral to the secure RST mailbox:* [*RST.Referrals@DBHDS.virginia.gov*](mailto:RST.Referrals@DBHDS.virginia.gov)*.*

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| --- | --- | --- | --- | --- |
| **Date completed:** Select date | **Agency:** Enter CSB/BHA/TC | | **Region of Agency:** Select region | |
| First name: Enter name | **Last name:** Enter name | | Suffix: ­­­­­­­­­­­­­­­­Select one | |
| **Unique ID:** Enter number | **Date of Birth:** Enter DOB | | **# Of Referrals to RST:** Select one | |
| **Referring party:** Enter referring party name | **Phone number:** Enter phone number | | **Contact email:** Enter email address | |
| **Supervisor:** Enter Supervisor | **Phone number:** Enter phone number | | **Supervisor’s email:** Enter email address | |
| **Current Living Situation**: Type of homeOther-please describe | **City/County (of current residence):** Enter city/county | | **Provider name:** Enter provider name | |
| **RST review requested in desired region:** Select region | | **City/County (of desired service location):** Enter city/county | | |
| If services are unavailable in desired region, services are considered in following regions: | | | Select region | Select region |

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| **Referral Criteria** | | |
| Request for an Emergency Meeting: Select one  Reason for Late Referral: Select one | Community Required: Select one | Training Center Required: Select one |
| Move in date: Enter date  Anticipated move in date: Enter date | Other: Select one | If Other is selected, please describe: Description |

**Unavailable financial support limiting access to resource/s (Check all that apply)**

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| --- | --- | --- |
| Medicaid: Select one | DD Waiver slot: Select one | Customized rate: Select one |
| Crisis funds: Select one | Housing Assistance: Select one | Other-please describe |

**Barriers related to Waiver Service Options or Other in desired location (Please use key below to identify barriers)**

|  |  |  |
| --- | --- | --- |
| 1. Employment and Day Options | Select unavailable service | List multiple services and barrier #(s) |
| 1. Self-Directed Options (may be Agency Directed) | Select unavailable service | List multiple services and barrier #(s) |
| 1. Residential Options | Select unavailable service | List multiple services and barrier #(s) |
| 1. Crisis Support Options | Select unavailable service | List multiple services and barrier #(s) |
| 1. Medical and Behavioral Support Options | Select unavailable service | List multiple services and barrier #(s) |
| 1. Additional Options | Select unavailable service | List multiple services and barrier #(s) |
| 1. Other | Description | List corresponding barrier number(s) |

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| Barrier Key (Choose all barrier numbers that apply and place in the applicable list above) | |
| 1 | Services not available under currently enrolled waiver |
| 2 | Services and activities unavailable in desired location |
| 3 | Community location is not adapted for physical access (not wheelchair accessible or ADA compliant) |
| 4 | Direct Support Staff- may not have experience or demonstrate competency to provide support with behavioral expertise |
| 5 | Direct Support Staff- may not have experience or demonstrate competency to provide support with mental health expertise |
| 6 | Direct Support Staff- may not have experience or demonstrate competency to provide support with medical expertise |
| 7 | Professional Behavioral staff- Psychiatric, PBS facilitator, Applied Behavioral Analyst, or other specialist unavailable |
| 8 | Professional Medical staff- Dental, nursing or any medical specialist unavailable |
| 9 | Accessible transportation unavailable |
| 10 | Individual/SDM/LG chooses less integrated option |
| 11 | Individual/Substitute Decision Maker (SDM)/Legal Guardian (LG) not interested in discussing/exploring options/refuses supports |
| 12 | Individual/SDM/LG does not choose provider after visit/still exploring community options |
| 13 | Frequent hospitalizations- medical and/or mental health hospitalizations |
| 14 | Delay in move and/or acceptance to a more integrated setting- due to unexpected or late medical interventions |
| 15 | Provider has determined placement is not a good match- provider is not willing/able to support individual |
| 16 | Service/Provider Development or Loss- Construction/Renovations/Environmental Modifications/Staffing/On-boarding/Licensing |
| 17 | Other (please list all other barriers below) |

**Provide any information you think may be helpful in the RST review process and/or other barriers not identified above.**

Enter case summary including diagnoses, medical/behavioral information, funding sources, legal status/history, etc.

**CIM/CRC Consultation Recommendations**

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