



# 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) Name(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Language spoken in the home: \_\_\_\_\_

## 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

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**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     No

***If yes, list dates*** \_\_\_\_\_

*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 14<sup>th</sup> Ave, Suite 100  
Portland, OR 97209  
Fax: (971) 673-2971  
Phone: (971) 673-2995