

VIRGINIA INFORMED CHOICE

The Virginia Informed Choice form is completed with an individual/substitute decision-maker (SDM) at following times: 1) enrollment into the Building Independence Waiver (BI), Family and Individual Supports Waiver (FIS) or Community Living Waiver (CL), 2) when there is a request for a change in waiver provider(s), 3) when new services are requested, 4) when the individual wants to move to a new location and/or is dissatisfied with the current provider or 5) when a Regional Support Team (RST) referral is made. DBHDS licensed providers can be found at: <http://www.dbhds.virginia.gov/professionals-and-service-providers/licensing/licensed-provider-search>. The CSB may also have information on Medicaid enrolled providers who have notified them of their license to provide services. Note that Substitute Decision-Maker (SDM) stands for either Authorized Representative or Legal Guardian.

FOR THIS INSTRUCTIONAL FORM, ALL INSTRUCTIONS ARE IN BOLD AND HIGHLIGHTED IN YELLOW.

NOTE: INCASE THE CHECK BOXES ARE NOT ACCEPTING YOUR CHECKS, PLEASE BOLD AND HIGHLIGHT YOUR CHOICES. To be able to do this, you will have to be using the unlocked version of the choice or referral form.

For this choice form, If only one service or provider is being considered select N/A in the blue section in Section 1 box of all options not being discussed and choose that service from the drop down here: Choose an item.

I have the following waiver. Please check correct box (only one box can be checked):

- Building Independence Waiver (BI) Yes
- Family and Individual Waiver (FL) Yes
- Community Living Waiver (CL) Yes

Complete sections 1 through 4 below to confirm that the following opportunities were discussed *before* making service choices under the waiver.

NOTE: IN SECTION 1: A BOX HAS TO BE CHECKED IN EACH OPTION (BOTH DISCUSSED AND CONSIDERED) SECTION UNLESS YOU CHECK THE N/A BOX IN THE BLUE SECTIONS (SEE BLUE ARROW BELOW). FOR EXAMPLE WHEN DISCUSSING OPTIONS, THE CHOICE FORM DOES NOT INCLUDE DISCUSSIONS ABOUT EMPLOYMENT AND DAY OPTIONS CLICKING THIS BOX (SEE BLUE ARROW) KEEPS YOU FROM CHECKING ANYTHING IN THE DISCUSSED OR CONSIDERED SECTION.

Section 1.
By marking yes or no or N/A, confirm that all of the following types of available options and ID/DD/DS services (as available under the Waiver received) were discussed. If not, confirm by marking yes or no if an option is being considered for this individual.

Options	Discussed	Considered	Applicable Waivers		
			BI	FL	CL
Employment and Day Options N/A <input type="checkbox"/>					
Individual Supported Employment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Group Supported Employment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Workplace Assistance Services	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Engagement	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Coaching	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Group Day Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Options	Applicable Waivers				
Self-Directed Options DON'T ANSWER IF N/A WAIVER (*can also be agency-directed) N/A <input type="checkbox"/>					
Consumer-Directed Services Facilitation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
CD Personal Assistance Services*	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Applicable Waiver section will tell you if the waiver the person has qualifies for the options/ services. If there is a N/A in the applicable waiver box, there is a corresponding N/A in the discussed section. Be sure to check the N/A in discussed section.

CD Respite*	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
CD Companion*	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Options	Discussed	Considered	Applicable Waivers		
Residential Options N/A <input type="checkbox"/>			BI	FL	CL
Independent Living Supports	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	N/A	N/A
Shared Living	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Living	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
In-home Support Services	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Sponsored Residential	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Group Home Residential	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Options	Discussed	Considered	Applicable Waivers		
Crisis Support Options N/A <input type="checkbox"/>			BI		CL

Note: Section 1 Example: For the residential options discussion, the person has a CL waiver (see #3 blue arrow). This tells you the person cannot live in Independent Living Supports, but all other options are available. In the discussed column, you should discuss all options that are available for the corresponding waiver. The example person said he would enjoy living in a sponsored residential home, or a group home. Group home includes both 4 beds or less and 5+ beds. The residential options discussed box would look like this (see #1 blue arrow). For all the options that have a yes checked in the CONSIDERED column, you MUST have a corresponding entry in Section 2. This means you need at least one sponsored residential (more than 1 is preferable), a couple of 3 or 4 bed group homes, and at least one 5+ bed group home.

Section 2 for this example: He indicated he would like to consider the sponsored residential and the group home residential. The SC and LG and individual toured the following homes. Notice the reasons selected or not selected. These reasons need to be specific. Answers like 'didn't like/liked' or chosen/ not chosen will not be sufficient and will be returned for more information.

Section 2.
For every option you marked yes in the considered column in section 1 above, at least one entry must be made in this table. This table will show your final decision. In making a decision, I/we considered, and/or interviewed and/or reviewed the following. After being provided information on the types of settings and services available under the waiver (see section 1 above) and in my preference for the state, I have freely chosen the following services, support coordinators, settings and providers as indicated by 'yes' marked below in Section 2.

Option Considered	Provider's Name and Location (City)	For Residential Settings list # licensed beds	Selected Yes or No	Reason(s) selected or not selected Be specific.
Sponsored Residential	ABC Residences, Smallsville, VA	2	Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/>	Did not like the location of the home. He said it was "too far from the mall."
Sponsored Residential	XYZ Residences, Tinytown, VA	1	Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/>	Did not like the layout of the house. He said it had "too many stairs." He can't navigate stairs due to his CP.
Group Home Residential	DEF Homes, Smallsville, VA	4	Yes <input checked="" type="checkbox"/> or No <input type="checkbox"/>	Liked that it had a gym within walking distance. There was also

				a strip mall within walking distance and a friend from his past lives here.
Group Home Residential	GHI Homes, Tynytown, VA	4	Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/>	Said he didn't like any of the people who lived there. He didn't appear comfortable. He kept asking when they were going to leave.
Group Home Residential	JKL Homes, Smallsville, VA	3	Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/>	LG did not like the proficiency of staff. She said they didn't seem to know the answers to some of her important questions.
Group Home Residential	MNO Homes, Tynytown, VA	5	Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/>	He didn't like the house rules as he wanted more independence to be able to walk to the mall and the gym without staff 'following him'. LG agreed with him and his lack of independence.
Choose an item.	Click here to enter text.	Click here to enter text.	Yes <input type="checkbox"/> or No <input type="checkbox"/>	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Yes <input type="checkbox"/> or No <input type="checkbox"/>	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Yes <input type="checkbox"/> or No <input type="checkbox"/>	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Yes <input type="checkbox"/> or No <input type="checkbox"/>	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Yes <input type="checkbox"/> or No <input type="checkbox"/>	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Yes <input type="checkbox"/> or No <input type="checkbox"/>	Click here to enter text.
Support Coordination	EZZE CSB	Click here to enter text.	Yes <input checked="" type="checkbox"/> or No <input type="checkbox"/>	LG and individual stated they
Section 3. Are any preferred options unavailable in preferred location? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			Note: important box (blue arrow) to collect information about options that still need to be built in the community. Please complete.	
If yes, list unavailable options:		Click here to enter text.		
Section 4.				
I have been offered the chance to talk with other individuals receiving BI/EIS/CL Waiver services who live and work successfully in the community or with their family members: Yes <input type="checkbox"/> No <input type="checkbox"/>				
If desired, you or your support coordinator/case manager may contact a DBHDS representative at (804) 201-3833 to connect with individuals and families who have waiver services. http://www.dbhds.virginia.gov/LPSS/LPSS.aspx .				
			New location for this information. Be sure to discuss with individual and AR/LG.	

RST Referral

RST Referral Form *RST Referral - DMAS-460/459A* must be completed if any of the following criteria is met:

- a. Difficulty finding services in the community within 3 months of receiving a slot.
- b. Choosing to move to a group home of five or more individuals.
- c. Choosing to move into a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
- d. Pattern of repeatedly being removed from home.

The Regional Support Team (RST) will review your selection of services to assure you have received information about all options available, explored supports and services in the most integrated settings, have knowledge of what's available to you in your preferred location and report on any preferred settings not available in your area. No action is required on your part and it is confidential. Any suggestions the RST offers will be shared directly with your support coordinator/case manager to follow up on with your consent.

I am aware of the fact that I may contact my Support Coordinator/Case Manager at any point to seek assistance with provider-related issues. I have the option of changing providers, including my Support Coordinator/Case Manager. I understand that under certain conditions (described above), a Regional Support Team referral will be completed by my Support Coordinator/Case Manager. I have been made aware of the right to a fair hearing and appeal process.

I am aware that I have the potential to pay for some of my cost (patient pay), based on my income, and for certain services received. I also understand that, if I chose Consumer-Directed Services, I bear the responsibility as the individual for my own personal assistants. I also understand there are services in the BI/FIS/CL Waivers for which I am responsible. I understand there is a lapse in services. (Initial)_____ (Initial)_____ (Initial)_____

The above information has been discussed with me. I understand that the Intellectual Disability/Developmental Disability Support Coordinator/Case Manager and provider(s) will develop a Person Centered Individual Support Plan /Plan of Care based on what I want and need. I understand that when selecting this option, I may have follow-up suggestions. (Initial)_____ (Initial)_____ (Initial)_____

Signature on file

Individual Signature/Date

Signature on file

ID/DD Support Coordinator/Case Manager Signature & Date

Signature on file

Substitute Decision Maker Signature (if applicable)

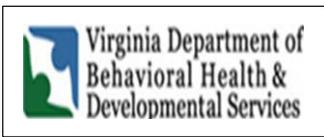
Check if the individual has already moved into a residential option. Enter date of move: _____

Check if RST Criteria met and RST referral is being completed.

This section where everyone has to initial is also new. Go over each paragraph and have the individual and AR/LG and individual initial they understand this information.

For RST referrals, we do not need signatures. We need the forms in word format. The SC keeps the signatures on file.

NOTE: When submitting this combined form for a RST referral, form must be in Word Format. Support Coordinator/Case Managers need the signatures on file. For purposes of the RST, the RST Coordinator or the RST members do not need the signatures.



Regional Support Team Referral

Regional Support Team Referral

(To be completed by SC/CM if any of the following criteria are met)

RST referrals are required when any of the following are true. Mark **only one** reason and forward to the assigned Community Resource Consultant(CRC) or RST Coordinator through secure email. If you don't have secure email, please email CRC/ RST Coordinator to send you a link:

Community SC/CMs complete the section highlighted yellow.

For individuals with I/DD **in the community** the following referral reason is primary:

- a. Difficulty finding services in the community within 3 months of receiving a slot.
- b. Moving to a group home of five or more individuals.
- c. Moving to a nursing home or ICF.
- d. Pattern of repeatedly being removed from home.

In which Region does this referral reason occur: **Originating Region:** Choose an item.

Training Center SC/CMs complete the section highlighted blue.

For individuals with I/DD **in training centers:**

- a. Moving to a nursing home, ICF-IID or group home with five or more individuals.
- b. Difficulty finding particular type of community supports within 45 days of discharge plan.
- c. PST cannot agree on a discharge plan outcome within 15 days of the annual PST meeting, or within 30 days after the admission to the Training Center.
- d-1. Individual or AR opposes moving despite PST recommendation.
- d-2. Individual or AR refuses to participate in the discharge planning process.
- e. Hasn't moved within three months of selecting a provider (requires identifying the barriers to discharge and notifying the facility director and the CIM).
- f. Recommended to remain in a Training Center (requires PST/CIM assessment at 90-day intervals).

In which Region does this referral reason occur: **Originating Region:** Choose an item.

Below highlighted yellow section is completed by all SCs and CMs. This requested information is self-explanatory. Community SCs complete information to grey box, skip grey box and then complete Reasons for Referral 1-8 located after the grey box.

- Individual's full name: [Click here to enter individual's name.](#)
- Individual's Unique ID: [Click here to enter unique ID.](#) Date of Birth: [Click here to enter date of birth.](#)
- Individual's current residence: [Click here to enter provider name and city.](#)
- What type of residence is current home? [Choose a type of home.](#)
- Date individual moved into this residence: [Click here to enter a date.](#) IF before December 31, 2012 you can leave blank.
- Has individual already moved into the home which necessitated this RST referral? Yes No N/A
- If yes, when was the move in date? [Click here to enter a date.](#)
- If no, when is anticipated move in date? [Click here to enter a date.](#)

Individual's current day activity: [Choose a day activity.](#)

Date SC/CM completes referral: [Click here to enter a date.](#) Region of Agency: [Choose a region](#)

Submitter: [Click here to enter submitter name.](#) Agency: [Click here to enter submitter agency.](#)

Contact phone number: [Click here to enter phone number.](#) Contact email: [Click here to enter email address.](#)

To be completed by TC staff and CRC staff only.

Training Center Referrals-Date CIM was notified of the need for referral: [Click here to enter a date.](#)

Training Center Referrals-Select the number of this referral. i.e. 1st referral, 2nd ...: [Choose Referral Number.](#)

Community Referrals-Date CRC was notified of the need for referral: [Click here to enter a date.](#)

Community Referrals-Select the number of this referral. i.e. 1st referral, 2nd ...: [Choose Referral Number.](#)

Note: All SCs/CMs complete Reason for referral 1-8.

Reason for referral

1. Provide any information you think may be helpful in the RST review process: (This is information such as previous homes or other relevant history, why the person wants/needs to move, previous environments where individual was successful or not successful, etc.) [Click here to describe.](#)

Note: Be very specific here. The more information you include here, the better the recommendations from the RST members.

2. If the individual or substitute decision-maker is choosing a **less integrated setting** (5 or more bed group home, community ICF-IID, Nursing Facility, Training Center, describe the reason(s) this setting is being selected: (Be specific). [Click here to describe reasons for selecting less integrated setting.](#)

Note: This is where you explain why a decision was made for a home larger than 4 beds – especially when the AR/LG was not open to looking at many options. This is a more detailed explanation than the simple specific explanation you provided in Section 2. This could help provide information showing that informed choice was given even if the individual and AR/LG only went to one home to look.

Note: Be sure to check yes or no for #3 – often this box is left blank.

3. Does the individual agree with the choice being made? Yes or No

4. What are the individual's diagnoses? [Choose all that apply:](#)

DD ID-Mild ID-Moderate ID-Severe ID-Profound ADHD Alzheimer's/Dementia Autism
Diabetes Feeding Tube MH-Personality DO MH-Schizophrenia MH-Mood DO Other MH DO Seizures
Other

If Other please describe: Cerebral Palsy (CP)

5. Detail any **medical concerns** that must be considered while making a home or employment decision: [Example: Due to individual's CP he cannot navigate stairs so house and employment must be on one level.](#)

6. Detail **behavioral concerns** that must be considered while making a home or employment decision: [Example: He does not like loud staff who tell him what to do in an authoritative voice. Staff should have person centered thinking training.](#)

7. Detail any **other concerns that must be considered** while making a home or employment decision: [Click here to enter comments.](#)

8. Where does the individual want to live and work? Region: [Choose an item.](#) Is there a specific area in region? [Click here to enter specific area or cities.](#)

Completed by SC/CM initially At least one barrier must be marked. Specifics of the barrier should be included in the Describe barrier(s) and what has been done to address them column.		Completed by Community Resource Coordinator/Community Integration Manager	
<u>Identified Barrier</u> (Check all that apply) ONE MUST BE MARKED	<u>Describe barrier(s) and what has been done to address them</u> SPECIFICS OF CHECKED BARRIER DESCRIBED IN THIS COLUMN	<u>CRC/CIM recommended actions.</u>	<u>RST recommended actions</u>
Residential			
<input type="checkbox"/> <u>Unavailable in desired location(R1)</u> <i>No 4 bed or less homes available in desired area</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Inability to obtain or use equipment in new environment(R2)</u> <i>Desired home does not have room to accommodate equipment such as trolleys, motorized wheelchairs, medical equipment.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Lack of financial resources(R3)</u> <i>No waiver slot.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Authorized Representative/Legal Guardian reluctance (R4)</u> <i>AR/LG wants individual to remain at current living setting or AR/LG wants the individual to move into a 5 bed or larger residential setting even though there is a 4 bed or less home available in desired location</i>	Click here to enter comments.	Click here to enter comments.	Click here to enter Additional comments.
Behavioral			
<input type="checkbox"/> <u>Unavailable in desired location(B1)</u> <i>The desired home lacks professional behavioral staff or lack of psychiatrist in area. Also includes providers who choose to only accept people with a certain level of behavioral care.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Lack of behavioral expertise(B2)</u> <i>DSPs in desired home are not trained in behavioral support. Depending on the level of</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.

<i>support, individual may require staff to have specific training such as proof of Autism training.</i>			
<input type="checkbox"/> <u>Lack of financial resources(B3)</u> <i>Desired home provider requires extra funding to support increased behavioral needs.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Lack of mental health expertise(B4)</u> <i>DSPs in desired home are not trained in mental health support</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
Medical			
<input type="checkbox"/> <u>Unavailable in desired location(M1)</u> <i>The desired home lacks professional medical staff-like 24 hour nursing care</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Lack of medical expertise(M2)</u> <i>DSPs in desired home are not trained in needed medical support.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Lack of financial resources(M3)</u> <i>Desired home requires extra funding to support increased medical needs. Usually supplies not covered by waiver or increased staff coverage due to medical issues.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
Accessibility			
<input type="checkbox"/> <u>Unavailable in desired location(A1)</u> <i>Non-residential accessibility issues such as work environments, leisure activities. Could also include lack of transportation to and from community activity.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Inability to obtain or use equipment in new environment(A2)</u> <i>Lack of Non-residential accessibility – like wheelchair accessibility to bowling alley or Hollister’s in the mall.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> <u>Lack of financial resources(A3)</u> <i>Desired non-residential setting requires extra funding to support accessibility needs or needs assistive technology that waiver won’t provider. Also could be needs extra staff support in community with no funding available.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.

Community Engagement			
<input type="checkbox"/> Unavailable in desired location(C1) <i>No feasible working or volunteering opportunities exist where the person lives.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
<input type="checkbox"/> Lack of financial resources(C2) <i>Requires extra funding to support increased staff needs so the person can work, volunteer or engage with others in the community. Also funding issues because current waiver won't support working environment needs like equipment or assistive technology for person to work.</i>	Click here to enter comments.	Click here to enter comments.	Choose an item. Click here to enter Additional comments.
Use for additional notes, email exchanges, actions taken, and results:			

Completed by TC-CIM/ SC/CM after recommendations received and followed:

Individual/Substitute Decision Maker final service decision(s):

4. Communicate back to RST Coordinator after recommendations followed – **Use recommendation documentation form to answer all the questions listed under #4:**

What date did TC-CIM/SC/CM receive recommendations from RST meeting: [Click here to enter a date.](#)

Final residential setting: [Choose an item.](#) Date individual moved if applicable: [Click here to enter a date.](#)

Final employment setting: [Choose an item.](#) Date individual started employment if applicable: [Click here to enter a date.](#)

Final day/alternative setting: [Choose an item.](#) Date individual started day/alternative setting if applicable: [Click here to enter a date.](#)

Comments: [Click here to enter comments.](#)

TC-CIM/SC/CM to return completed RST Recommendation Documentation Form to RST Coordinator after all recommendations are followed or RST referral is resolved.

Completed by RST COORDINATOR	
Date completed RST referral received by RST Coordinator:	Click here to enter a date.
Is the Referral for Non-Residential Supports?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date referrals sent to Regional Support Teams. (Prior to meeting):	Click here to enter a date.
RST Meeting Date:	Click here to enter a date.
Date RST Recommendations sent to PSTs/CIMs/SCs:	Click here to enter a date.
Date RST Coordinator followed up for service decisions/recommendations, if applicable:	Click here to enter a date.
RST recommendations followed:	Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/>
DATE RST CLOSED:	Click here to enter a date.
DATE Individual Moved or Found Integrated Day:	Click here to enter a date.
REASON INDIVIDUAL MOVED TO LESS INTEGRATED SETTING:	Choose an item. Click here to enter Additional comments.
FINAL DISPOSITION Residential:	Choose an item. Click here to enter Additional comments.
FINAL DISPOSITION Barrier-Medical:	Choose an item. Click here to enter Additional comments.
FINAL DISPOSITION Barrier-Behavioral:	Choose an item. Click here to enter Additional comments.
FINAL DISPOSITION Barrier-Accessibility:	Choose an item. Click here to enter Additional comments.
FINAL DISPOSITION Barrier-Community Engagement:	Choose an item. Click here to enter Additional comments.