Comprehensive Assessment & Social History (CASH) Referral Form

Instructions
Complete this form to request a CASH review for members who are eligible and need Habilitation Services. Please complete this form and send to: ITC_LOCUS@IowaTotalCare.com.

For information about services and eligibility, visit the Iowa Department of Health and Human Services' Habilitation Services webpage (hhs.iowa.gov/medicaid/services-care/habilitation-services#eligibility) under "Eligibility."

Referring Party Information

Name of person making referral: _____

Agency name (if applicable): _____

Relationship to the member: _____

Phone: _____ Email: _____

Eligibility Information
Does the member consent to this referral and agree to apply for Habilitation Services?

☐ Yes ☐ No

Is the member eligible for Habilitation Services?

☐ Yes ☐ No

Facility Information (if applicable)

Name of facility: _____

Phone: _____ Email: _____

Member Information

Legal name: _____

Medicaid ID number: _____

Address: _____

City: _____State: _____ ZIP code: _____

Phone: _____ Email: _____

Please list the member's medical and/or behavioral diagnosis(es):

_____

_____

_____

Does the member have a legal guardian or a representative responsible for their care or decisions?

☐ Yes ☐ No

If yes, please provide the following information:

Name of guardian/representative: _____

Relationship to the member: _____

Phone: _____ Email: _____

Type of guardianship:

☐ Legal guardianship

☐ Medical power of attorney

☐ Parent/guardian of minor

☐ Other: _____

Please add contact information for anyone who helps with members' care.

Name: _____

Phone: _____ Email: _____

Name: _____

Phone: _____ Email: _____

Name: _____

Phone: _____ Email: _____

Please describe the member's need(s) for Habilitation Services:

_____

_____

_____

_____

What service(s) is the member in need of? *Select all that apply.*

☐ Home-Based Habilitation

☐ Day Habilitation

☐ Prevocational Services

☐ Support Employment