BE Home-IDD Referral Form

Bayaud Enterprises Housing Options Mean Everything

For Residents of The City and County of Denver
With Intellectual and Developmental Disabilities
Please complete and email to:
BEHOME-IDD@BayaudEnterprises.org or call 720-979-2645

Note to Referring Agency: If you are completing this form for a participant, please submit your agency's Release of Information for Bayaud Enterprises, or complete the attached Bayaud Enterprises ROI.

Participant Legal Name:_____ Preferred Name (if any): _____ Date: _____

Does the participant have a confirmed Intellectual and Developmental Disability (I/DD)? Select One Below

☐ Yes, Confirmed I/DD ☐ No, but I/DD is suspected ☐ No

Current/History of Special Education? ☐ Yes ☐ No ☐ Unsure

Participant Phone Number(s): _____

Participant Email (if any): _____

DOB: _____ Gender: _____ Address: _____ City: _____ State____ Zip code_____

Referral Source Name: _____

Referral Source Relationship/Agency: _____

Referral Source Phone Number: _____ Referral Source Email: _____

Reason(s) For Referral (Check all that apply and describe on next page):

☐ Homeless ☐ At-Risk of Homelessness for Financial Reasons ☐ At-Risk of Homelessness for Other Reasons:
☐ Aging Caregiver ☐ Interested in Home Ownership

Participant Primary Language: _____

Caregiver Name(s) and Relationship(s): _____

Caregiver Phone/Email: _____ Caregiver Primary Language: _____

Participant Guardian(s): Self/Other(s) List name/contact details: _____

Participant Strengths: _____

Other Services Receiving/Applied For if any: _____

Housing Status: Check One Below

☐ Homeless and Unsheltered ☐ Homeless and Sheltered ☐ Renting ☐ Own Home ☐ Staying with Friends ☐ Family Home
☐ Group Home ☐ Host Home ☐ Assisted Living Facility ☐ Hospital ☐ Jail/Prison
☐ Housed and seeking other options ☐ Other (Describe): _____

Housing and Related Details, check all that apply, and provide details if known.

☐ Housing Voucher Type: _____ ☐ At-risk of Eviction/Placement Loss/Housing Unstable: _____ ☐ Conviction History: _____ ☐ Previous Eviction: _____ ☐ Interested in long-term planning.

☐ Cash Income, Type (Working, SSI/SSDI, Retirement etc.) Total Monthly Cash Income: _____

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Notes: (Housing Status, Resources, Household Members, Disability-Related, or Other Relevant Information):

BAYAUD ENTERPRISES
Employment Matters

Bayaud Enterprises

333 W Bayaud Ave
Denver, CO 80223

AUTHORIZATION TO RELEASE AND/OR OBTAIN CLIENT INFORMATION

OBTAIN FROM/RELEASE TO:	**RELEASE TO/OBTAIN FROM:**
_____ Name Relationship	(Written, Verbal and/or Electronic) Bayaud Enterprises *
_____ Address	333 W Bayaud Ave.
_____ City State Zip Code	Denver, CO 80223
_____ Phone Fax	(303) 830-6885 (Telephone)
	(303) 830-6653 (Fax)
	ATTN:

I hereby authorize Bayaud Enterprises to:
☒ **obtain from the following** ☒ **release to the following**

Identifying Information: Date of Birth:

Client Name: SSN:

Dates of Service and/or Hospitalizations Requested (If left blank, all dates of service): _____ to _____

Specific Information Requested:

- ☐ Admission History, Discharge Summary, Progress Reports
- ☐ Psychiatric History, Including Diagnosis and Treatment
- ☐ Full Psychological Evaluation
- ☐ X-ray/MRI/EKG/CT Scan Reports
- ☐ Drug/Alcohol History and Treatment
- ☐ Pregnancy Records
- ☒ Other: Information needed for I/DD Housing Navigation Program
- ☐ Physical Exam/Consultation
- ☐ Psychological Testing/Consultation
- ☐ Lab Studies
- ☐ X-ray, EKG, MRI, CT Scan Images
- ☐ Educational/IEP/SPED Records

The Information Above Is To Be Used For:

- ☒ Assessment
- ☒ Service Planning
- ☒ Continuity of Care
- ☐ Other:

I understand that a copy of this authorization is to be considered as valid as the original and that this authorization will expire on ___/____/____, or if left blank, one year from date of my signature. I may revoke this authorization at any time and to do so I must sign the *Revocation Section* below. I understand that Bayaud Enterprises may release this information to any county, state, or federal agency and/or my legal representatives. Client initial: _____

I understand that my information pursuant to the authorization may not be protected from re-disclosure by the recipient of this information and no longer protected by the federal privacy regulations; however, if this information is protected by the Federal Substance Abuse Confidentiality regulations (42 C.F.R., part 2), the recipient may not re-disclose such information without my express authorization above unless otherwise provided for by state or federal law.

I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization for release of information.

I understand that information to be released might include information regarding the following condition(s):

- ☐ Drug Abuse
- ☐ Psychiatric Conditions
- ☐ Alcoholism or Alcohol Abuse
- ☐ HIV/Auto Immune Deficiency Syndrome (AIDS)

_____ Client Signature Date

_____ Client guardian signature Date

_____ Bayaud Enterprises Staff Member

I hereby revoke this Authorization to Release or Request for the above Information

_____ Client _____ Date _____ Witness _____ Date