BRIGHT HORIZON THERAPY CENTER INC

**TRANSITIONAL SERVICES REFERRAL FORM**

**Recipient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Instruction Sheet**

**Form must be filled out in full before BHTC can process referral**

**Complete ALL Sections (see attached sheets)**

**Recipient and Case Manager Signature required (last page)**

**Please allow 7-15 days for referral processing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provider Name** | **NPI Number** | **Description** | **Procedure Code** | **Maximum**  **Amount** |
| **BHTC** | 1598313710 | Moving Services, Delivery,  Damage Deposit, Application Fee, Mileage & Labor | T2038 | $1700.00 |
| **BHTC** | 1598313710 | Furniture | T2038-U1 | $1000.00 |
| **BHTC** | 1598313710 | Household Items | T2038-U2 | $300.00 |

**Please note that BRIGHT HORIZON THERAPY CENTER (BHTC) will bill for labor**

* $62/hour for Furniture Acquisition and Household Items Acquisition.
* $165/hour for Moving and Packing/ Unpacking.
* Mileage is calculated at 54 cents/mile.

**\*Effective July 1, 2018 individuals on Housing Access Coordination (HAC) are eligible to receive Transitional Services. Please visit the DHS website for Transitional Services updates. \***

**Client Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: | | | M.I.: | Last Name: | | | |
| Date of Birth: | Gender:  Male  Female  Prefer not to answer  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Race: | | SSN: |
| Diagnostic Codes and Descriptions: | | | | | | | PMI #: |
| Phone Number: | | Cell Number: | | | | E-mail address: | |

**Contacts (please fill out all contact information)**

|  |  |
| --- | --- |
| **Case Manager** full name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Best Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Case Manager Supervisor** full name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Best Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Relocation Service Coordinator** full name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Best Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Care Coordinator** full name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Best Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Payments Source:**  CAC  CADI  BI  DD  MHM

**Service Provider:**  U-Care  Medica  Bridgeview

**Current Address (Complete only if movers need to pick up belongings**)

|  |  |  |
| --- | --- | --- |
| Address and Unit Number: | City: | Zip code: |

**Storage Facility (Complete only if movers need to pick up items)**

|  |  |  |  |
| --- | --- | --- | --- |
| Facility Name: | | Unit: | |
| Address: | City: | | Zip code: |

**New Address**

|  |  |  |
| --- | --- | --- |
| Address and Unit Number: | City: | Zip code: |

**Move Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Transitional Services Information**

**Community Support Plan (CSP) authorized Services\*\*\*: (mark all that apply)**

|  |
| --- |
| Move personal items from licensed facility or storage unit to Individual’s new home. (T2038)  Purchase **One-Time** Furniture items. (T2038 – U1) **(See list on next page)**  Purchase **One-Time** Household items/ Cleaning Supplies. (T2038 – U2) **(See list on next page)** |

**\*\*\*Please note all lines MUST be authorized prior to providing services. BHTC requires a Service Agreement screenshot prior to providing any services.**

**Apartment Size:**  **Studio**  **1 bedroom**  **2 bedrooms**

**Color Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (may not be available)**

**(T2038) Moving Expenses/ Damage Deposit/ Application Fee:**

|  |  |
| --- | --- |
| **Damage Deposit:**  Yes  No  (Damage deposit cannot exceed **$500.00** and will not be available until day of move. Letters guaranteeing payment will be sent out prior to move.) | **Amount: $\_\_\_\_\_\_\_\_\_** |
| **Application Fee:**  Yes  No  (Application fee cannot exceed **$50.00** and will not be available until day of move. Letters guaranteeing payment will be sent out prior to move.) | **Amount: $\_\_\_\_\_\_\_\_\_** |

**Payment Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name Payable To: | | Phone Number: | | |
| Billing Address: | City: | | State: | Zip code: |

**(T2038-U1) Essential Furniture: (not to exceed $1,000) (Only check items needed)**

**If all items are checked, individual will receive some used furniture.**

Bed frame\*  Mattress\*  Box Spring\*  Dresser

Floor Lamp  TV Stand  Dining Table & Chairs ( 2 Chairs  3 Chairs)

Night Stand  Table Lamp  Sofa/Couch ( 2 Cushions  3 Cushions)

**\*Twin Bed, unless body size deems otherwise**

**(T2038-U2) Household Supplies: (not to exceed $300) (Only check items needed)**

Sheets - Size \_\_\_\_\_ (Twin/ Twin XL/ Full/ Queen) **(hospital beds generally require Twin XL sheets)**

1 Pillow  Bed in a bag (Comforter/ Pillowcases/ Sheets)

1 Blanket  Clock

Toaster  Coffee Pot

Pots/Pans  Mixing bowls

Strainer  Kitchen linens (Towels/ Potholders/ Washcloths)

3 pc Knife Set  Utensil Cooking Set

Small Cutting Board  Dishes

Silverware  Drinking Glasses (4 plastic)

Dish Rack with Tray  Kitchen Garbage Can

Bathroom Garbage Can  Garbage Bags

Paper Towels  Toilet Paper

Kleenex  Bathroom linens (Towels/ Washcloths)

Hangers (set of 10)  Hamper

Broom w/dustpan  Mop

Toilet Brush  Sponge/dish soap

Cleaning Supplies  Shower Curtain and Rings

Laundry Detergent  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Microwave **(All Above items may not be purchased if this box is checked)**

Slow cooker **(All Above items may not be purchased if this box is checked)**

Stick Vacuum **(Only if requested and funds are available)**

**Important Notices: (Please read before signing)**

* It is required that a member of the client’s care team is present on-site on the move date.
* All outside referral clients are responsible for packing before the move date. Any **BHTC** HAC Clients are eligible for packing assistance.
* Please note that **BHTC** will bill for labor.
* Please be aware that it is the client’s/ care team’s responsibility to find and secure an agreement with a moving company (reference available).
* Please be aware that it is the client’s/ care team’s responsibility to clean up after move.
* MCHS is limited to a 35-mile moving radius from original location to the new housing address.
* MCHS requires a Service Agreement screenshot prior to providing any services.
* Effective July 1, 2018 individuals on Housing Access Coordination are eligible to receive Transitional Services. Please visit the **DHS** website for Transitional Services updates.

**Form must be filled out in full before BHTC can process referral**

**Recipient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager Approval Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Case Manager E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager’s Supervisor Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager’s Supervisor E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please **FAX** referral form with signatures to (**952) 960-0137 Attn: Sahra Hassan**

Or **E-mail** [info@brighthorizonmn.net](mailto:info@brighthorizonmn.net) - Subject: “**TS Referral Form**”

If you have any questions, please call **(952) 232-6900**