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Adaptation & Modification Referral Form

***All New Referrals need to include an Authorization for Release of Confidential Information**

PART 1: Participant Information

Name: _____ Contact Phone: _____
 Address: _____ Date of Birth: _____
 Gender: Male Female Other
 Contact Email: _____
 Date of Referral: _____ Height: _____ Weight: _____
 Diagnosis Code: _____ M.A.#: _____
 Client Characteristic Code: _____ DCDHS ACS#: _____
 Waiver: CLTS IRIS FCW FC CIP Waiver
 Guardian: _____ Guardian Phone: _____
 Guardian Email: _____

Part 2: Support Services Contact Information

Case Manager / IC/ Care Manager: _____
 CM Email: _____ CM Phone: _____
 Behavioral Consultant: _____
 BC Email: _____ BC Phone: _____

Part 3: Modification Site Visit Information

Modification to: Home Work Other Describe: _____
 Site Address: _____
 Site Contact: _____ Contact Phone: _____
 Site Contact Email: _____
 Best time to visit/notes: _____

Part 4: Time frame for project completion:

ASAP Within next month Three months Other Describe: _____

PART 5: Area of Interest, Targeted Modification / Adaptation or Task

#1. _____

In Behavioral Support Plan? No Yes

Restrictive Measure? No Yes

If "Yes," must be cleared by Restrictive Measures Committee

Expected Funding Source: _____

Other related information: _____

#2. _____

In Behavioral Support Plan? No Yes

Restrictive Measure? No Yes

If "Yes," must be cleared by Restrictive Measures Committee

Expected Funding Source: _____

Other related information: _____

#3. _____

In Behavioral Support Plan? No Yes

Restrictive Measure? No Yes

If "Yes," must be cleared by Restrictive Measures Committee

Expected Funding Source: _____

Other related information: _____

Part 6: Project visit information (RSI use only)

Regarding records of:

Name: _____ **Date:** _____

Address: _____ **Phone:** _____

Date of Birth: _____

Last four digits of Soc. Sec. #: _____

I authorize Responsive Solutions, Inc. to disclose and receive information and records to and/or from the following person/organization/agency:

Name: _____ **Phone:** _____

Address: _____ **Email:** _____

The information requested from my records will be used in connection to Crisis Response and Support Services and Adaptation and Modification Program Services. The purpose of such disclosure is to gain information regarding:

Disclosure under this release includes access to records, permission to obtain copies of records, and oral discussion of information between agency staff and individual service providers.

I understand that this consent to disclose may be revoked by me in writing at any time except that information already released with my consent may continue to be used to complete actions already taken. This consent expires one year from the date of signature, unless expressly revoked earlier. A photocopy of this authorization has the same effect as the original.

Signature of Program Participant _____ **Date** _____

Signature of Parent / Guardian _____ **Relationship** _____

Signature of Witness _____

Email this release, along with Adaptation & Modification Referral Form to info@responsivesolutions.org