



SUPPORTS INTENSITY SCALE (SIS) REFERRAL FORM INSTRUCTIONS

The DHHS Office of Aging & Disability Services, (OADS) has contracted with Gould Health Services (GHS) to provide the Supports Intensity Scale (SIS) for all adults with Intellectual Disabilities and Autism receiving or on the waitlist for MaineCare Section 21 Waiver Services. In order to streamline the assessment process, attached you will find an assessment referral form along with instructions for its use.

Pre- Planning Phase:

- As part of the referral process, the Individual and/or Guardian(s) must be contacted to explain the SIS assessment process. During this conversation with the Individual and/or Guardian(s) there should be a discussion about proposed Respondents for the SIS assessment. This can be generally identifying which service provider agencies should be present. Or it can be more specific, identifying the individuals who will serve as Respondents. Ideally Respondents will include representatives from home supports, community supports and work supports.
- Confirm with the Guardian(s) if they will participate in the SIS assessment. If they will participate, explain the acceptable reasons for cancellation, as outlined in policy and procedure. Ensure the Guardian(s) know that the consumer must be present during the interview, or be observed by the interviewer prior to the interview. Determine if the guardian(s) will be a Respondent or an Observer.
- If the Guardian(s) does not wish to be present, confirm their understanding that the SIS assessment will proceed without them.
- Document the conversation with the Individual and/or Guardian in EIS to reflect the discussion including the Guardian(s) wishes regarding their participation.

Instructions on Use of the Form:

1. Enter Consumer Information – Name, EIS #, Gender, - PCP Date, Date of Birth and MaineCare Number
2. Provide Contact Information for Consumer- Address, Phone etc.
3. Provide information about accommodation or assistive technology needs
4. Provide information for ALL Guardians, including contact information and indicate their participation in the SIS assessment.
5. Provide information about applicable Contact Persons for service providers who are to be potential Respondents. Note: this is not necessarily who will be the Respondent, but the best contact person to arrange a Respondent from each service represented. (For Example: House Manager for Group Home who will be able to best identify the appropriate respondent for their specific service area.)
6. Provide any pertinent information that might be necessary for GHS to know of, for example space accommodations, allergies, health concerns etc.
7. In order for GHS to schedule a SIS Assessment, the DHHS Release of Information must be attached and returned with this Referral Form.
8. Please return the referral form and Release of Information to Roberta Leonard by fax or password encrypted email at: Fax: 844-892-2705 or Email: rleonard@ghsinc.com
9. For further information please see entire policy and procedure in relation to SIS Interview Protocol at: <http://www.maine.gov/dhhs/oads/disability/ds/sis/index.shtml>
10. SIS assessments will be conducted every three years. Any exceptions to the three year time frame must be approved by the DHHS OADS SIS Manager, and noted at the bottom of the referral form.

SUPPORTS INTENSITY SCALE (SIS) REFERRAL FORM

SUPPORTS INTENSITY SCALE (SIS)

ADULTS WITH INTELLECTUAL DISABILITIES AND AUTISM
RECEIVING MAINECARE SECTION 21 WAIVER SERVICES



**IF YOU NEED ASSISTANCE WITH COMPLETING THIS FORM OR
HAVE GENERAL QUESTIONS ABOUT SIS, PLEASE VISIT assessmaine.com/SIS OR
CALL GOULD HEALTH SYSTEMS AT 1-800-609-7893 ext. 1598. OR 207-622-7153 ext. 1598**

**SIS POLICY IS AVAILABLE ON THE DHHS WEBSITE:
<http://www.maine.gov/dhhs/oads/disability/ds/sis/index.shtml>**

CONSUMER INFORMATION				
LAST NAME	FIRST NAME	M. I.	DATE OF BIRTH	REFERRAL DATE
MAINECARE NUMBER	PCP DATE	GENDER M <input type="checkbox"/> F <input type="checkbox"/>		EIS NUMBER
DATE OF PREVIOUS SIS, IF APPLICABLE				
CONSUMER'S CURRENT LOCATION (ASSESSMENT LOCATION)				
STREET ADDRESS		TOWN, STATE, ZIP CODE		PHONE
INTERPRETER NEEDED? Y <input type="checkbox"/> N <input type="checkbox"/> IF YES, DESCRIBE		ASSISTIVE DEVICES USED		
PERSON TO CONTACT ON BEHALF OF THE CONSUMER				
Please provide contact information for ALL guardians.				
GUARDIAN NAME			PHONE	
MAILING ADDRESS			TOWN, STATE, ZIP CODE	
GUARDIAN NAME			PHONE	
MAILING ADDRESS			TOWN, STATE, ZIP CODE	
SIS INTERVIEW PARTICIPATION				
GUARDIAN(S) WILL PARTICIPATE IN THE SIS INTERVIEW			Y <input type="checkbox"/> N <input type="checkbox"/>	
CONSUMER WILL PARTICIPATE IN THE SIS INTERVIEW			Y <input type="checkbox"/> N <input type="checkbox"/>	
CASE MANAGER WILL PARTICIPATE IN THE SIS INTERVIEW			Y <input type="checkbox"/> N <input type="checkbox"/>	
CASE MANAGER INFORMATION				
CASE MANAGER NAME		AGENCY		PHONE
MAILING ADDRESS		TOWN, STATE, ZIP CODE		CELL PHONE
EMAIL ADDRESS				FAX

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OTHER CONTACTS

Provide information about applicable Contact Persons for service providers who are to be potential Respondents. **Note:** the contacts entered here are not necessarily who will act as a Respondent, but are the best contact person to arrange for a Respondent from each service represented. (For Example: House Manager for Group Home who will be able to best identify the appropriate respondent for their specific service area.)

RESIDENTIAL CARE PROVIDER CONTACT	AGENCY	PHONE
MAILING ADDRESS	TOWN, STATE, ZIP CODE	FAX
EMPLOYMENT SUPPORT PROVIDER CONTACT	AGENCY	PHONE
MAILING ADDRESS	TOWN, STATE, ZIP CODE	FAX
EMPLOYMENT SUPPORT PROVIDER CONTACT	AGENCY	PHONE
MAILING ADDRESS	TOWN, STATE, ZIP CODE	FAX
COMMUNITY SUPPORT PROVIDER CONTACT	AGENCY	PHONE
MAILING ADDRESS	TOWN, STATE, ZIP CODE	FAX
COMMUNITY SUPPORT PROVIDER CONTACT	AGENCY	PHONE
MAILING ADDRESS	TOWN, STATE, ZIP CODE	FAX
OTHER (Family, Correspondent, etc.) CONTACT	RELATIONSHIP	PHONE
MAILING ADDRESS	TOWN, STATE, ZIP CODE	FAX

ADDITIONAL NOTES & INFORMATION

For example: space accommodations, allergies, health concerns etc.

ASSESSMENT APPROVAL

SIS assessments will be conducted every three years. Any exceptions to the three year time frame must be approved by the DHHS OADS SIS Manager, and noted on this referral form.

SIS REASSESSMENT APPROVED BY OADS SIS MANAGER Y N APPROVAL DATE

PLEASE ATTACH THE SIGNED DHHS RELEASE OF INFORMATION TO THIS FORM AND FAX TO GOULD HEALTH SYSTEMS (GHS) AT THE NUMBER BELOW SO THAT GHS MAY SCHEDULE THE ASSESSMENT PROMPTLY.

By initialing below, I wish for my release to include the following types of records:

_____ **Mental health treatment provider or program**

_____ **Substance/Alcohol/drug abuse treatment provider or program**

_____ **HIV infection status or test results: Maine law requires us to tell you that releasing this information may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.**

I (individual/personal representative of individual named above,) give permission to the DHHS office(s) listed above to release and/or share my records as written on this form. This form will remain in effect for one year from the date below. Other releases of my information are permitted during that time unless I revoke this form.

I further understand and agree that:

- DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form, unless I need to sign this form so that the right offices of DHHS can decide if I qualify for benefits.
- I have the right to make a written request to access and copy my healthcare or billing information, and a copy fee will be charged as permitted by law.
- If I want a review of my mental health program or provider records before they are released, I can check here. I understand that the review will be supervised.
- I may take back my permission to share the records listed on this form at any time by contacting the Privacy Officer of the specific DHHS office at:

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- I understand that taking back my permission does not apply to the information that was already shared with my signature on this form. If I revoke my permission, it may be the basis for denial of health benefits or other insurance coverage.
 - I may refuse to disclose all or some health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
 - DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by confidentiality laws.
 - If alcohol or drug provider or program records are included in this release, DHHS will tell the person receiving the records that they may not be shared with others who are not on this form without my written permission, unless required or permitted by law.
 - I am signing this form voluntarily and I have a right to a signed copy of this form if I request one.

Date: _____ **Signature** _____

Personal Representative's authority to sign: _____