**VIDES Request Form Instructions**

* *The facility Social Worker or Designee completes the VIDES Request Form for individuals seeking placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).*
* *Submit the VIDES Request Form via secure email to:* *Vides.request@dbhds.virginia.gov**.*

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| **Date of Request:** Enter date |
| **Reason for Request:** Enter reason |
| **Contact Information** |
| **Facility:** Enter ICF/IID | **Facility Address:** Enter address | **Facility Region:** Select region |
| **Facility contact:** Enter facility contact | **Phone number:** Enter phone number  | **Contact email:** Enter email address |
| Individual’s full name: ­­­­­­­­­­­­­­­­Enter name  | **Medicaid ID:** Enter number | **Date of Birth:** Enter DOB |
| **Current Living Situation**: Type of homeOther | **Address:** Enter address | **Phone number:** Enter phone number  |
| **Family/Substitute Decision Maker (SDM):** Enter name | **Relationship to individual:** Select one |
| **Address:** Enter address | **Phone number:** Enter phone number | **Email:** Enter email address  |
| **Name of person requesting admission for the individual:** Enter name  | **Relationship to individual:** Select one |
| **Address:** Enter address | **Phone number:** Enter phone number | **Email:** Enter email address  |

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| **Have you contacted the \*home Community Services Board/Behavioral Health Authority (CSB/BHA)?** Select one*(\*refers to the local CSB/BHA of the individual’s home address)*  |
| Name of CSB/BHA: Enter name | CSB/BHA Contact: Enter name |
| **Has a Regional Support Team (RST) Referral been completed?** Select one*(if yes, date submitted:* Enter date *)*  |
| **Has the individual been provided informed choice?** Select one |
| **Is the individual at risk for any of the following?** Select one Other |

**Provide any information you think may be helpful in supporting the individual’s need for ICF/IID services.**

Click here to enter text