|  |
| --- |
| Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) Request Form |
| Form Instructions |
| The facility Social Worker or designee shall complete the VIDES Request Form for individuals seeking placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).* Each question should be answered.
* Submit the VIDES Request Form via secure email to: Vides.request@dbhds.virginia.gov.
 |
| **Date of Request:** Click or tap to enter a date.**Reason for Request:** Click or tap here to enter text. |
| Facility Contact Information |
| **Facility:** Choose an item. | **Facility Contact:** Contact’s Name. |
| **Address:** Facility Address |
| **Region:** Choose an item. | **Facility Phone #:** (XXX) XXX-XXXX |
| **Email:** Email Address |
| **DEMOGRAPHIC INFORMATION** |
| **Name:** Individual’s Full Name | **Email:** Email Address. |
| **Medicaid ID:** Medicaid ID # | **SSN:** Social Security Number |
| **Date of Birth:** Select DOB | **Current Living Situation:** Choose an item. |
| **Address:** Current Address |
| Family/legal guardian/substitute decision maker (SDM) |
| **Name:** Individual’s Full Name | **Relationship:** Choose an item. |
| **Phone:** (XXX) XXX-XXXX | **Email:** Email Address. |
| **Address:** Current Address |
| Referral source |
| **Name:** Individual’s Full Name | **Relationship:** Enter Text |
| **Phone:** (XXX) XXX-XXXX | **Email:** Email Address. |
| **Address:** Current Address |
| CSB/BHA Information |
| **Name of CSB/BHA:** Enter Text | **CSB/BHA Contact:** Enter Text |
| **Is the individual at risk for any of the following:** Choose an item. |



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

Click or tap here to enter text.