

REFERRAL FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER Nursing Home Transition and Diversion (NHTD)

Transferred from: _____
(RRDS Region)

Referral # _____
(Date YYYYMMDD + Region number + R + referral counter,
Ex. 20061015-02-R012)

Applicant Name: Mr. Mrs. Ms _____
(First/MI/Last/Generational Suffixes)

Date of Initial Referral: _____ Region: _____

Applicant Information

Current Telephone: () _____ Medicaid Active: Yes No Unknown

Current Location:

- Private Residence Hospital Physical Rehabilitation Facility Psychiatric Facility
 Nursing Home Adult Home/Assisted Living Substance Abuse Rehab. Facility
 Jail/Prison Other: _____

Location Address: _____
Street

City State Zip

Comments: _____

Is Applicant: Diverting from: Transitioning from:
 In-state Out of State In-state Out of State

Is applicant proficient in English? Yes No

Does the applicant need a translator? Yes No If yes, what language? _____
Does applicant need a sign language interpreter? Yes No

If yes, translation/interpretation provided by: _____

Telephone: () _____ Telephone: () _____

Does applicant require written materials in alternative formats? Yes No

Specify: _____

Contact Information

Legal Guardian Yes No

Name (if applicable): _____ Telephone: () _____

Contact Person Name: _____ Relationship to Applicant: _____

Address: same as above _____
Street

City State Zip

Telephone: () _____

Referral Form (continued)

Applicant Name: _____	Referral # _____
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Demographics

Applicant Age: _____ Applicant Sex: Female Male

Applicant Birth Date (if known): ___/___/____ Marital Status: Single Married
 Separated Divorced Widowed

Referral Information

Reported Primary Diagnosis: _____

Areas of Concern: _____

Currently Living With: Alone Spouse Adult Children Minor Children Parents
 Siblings Other Family Members Friends/Significant Others Other _____

Onset of Needs Occurred Within: the last 3 months last 3-6 months last 6-12 months
 last 1-2 years last 2-5 years more than 5 years

Does Applicant have help in the home now? Yes No
If yes, specify type of service(s): _____

Proposed Living Arrangements

Proposed Region: _____ Proposed County: _____

Proposed Address: same as Current Location above Unknown

Street	City	State	Zip
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Proposed Living Situation: _____

Referral Source

Self Referral Comments: _____

Informal Referral Same as Contact Person above

Name: _____ Relationship to Applicant: _____

Telephone: () _____ Informal referral comments: _____

Referral Form (continued)

Applicant Name: _____ **Referral #** _____

Formal Referral

Provider Name: _____ Telephone: (____) _____

Referral Source type:

- | | | |
|--|--|---|
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Adult Home/Assisted Living | <input type="checkbox"/> Criminal Justice |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Medical Personnel | <input type="checkbox"/> Community Based Services |
| <input type="checkbox"/> MDS data | <input type="checkbox"/> Physical Rehab. Facility | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Independent Living Center | <input type="checkbox"/> Psychiatric Facility | |
| <input type="checkbox"/> Local Department of Social Services | <input type="checkbox"/> Substance Abuse Rehab. Facility | |

Provider Contact/Title: _____ Email: _____

Formal Referral Comments: _____

How did the referral source learn about the waiver?

- | | | |
|--|--|--|
| <input type="checkbox"/> RRDC | <input type="checkbox"/> Local Department of Social Services | <input type="checkbox"/> Psychiatric Facility |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Home Care Agency | <input type="checkbox"/> Substance Abuse Rehab. Facility |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Medical Personnel | <input type="checkbox"/> Media (TV, Radio, Newspaper) |
| <input type="checkbox"/> Point of Entry | <input type="checkbox"/> Staff from other waiver | <input type="checkbox"/> Pamphlets |
| <input type="checkbox"/> Independent Living Center | <input type="checkbox"/> Physical Rehab. Facility | <input type="checkbox"/> Other: _____ |

Outcomes – this section to be completed by RRDC

Referral Status: Proceed to Intake Date: __/__/____ Closed Date: __/__/____

Transferred to: _____ Date: __/__/____ Comments: _____

If closed, why? Age Medicaid status Medically unstable Choose to stay in Nursing Home
 Unable to contact Other: _____

Referral made to other resource(s): Point of Entry TBI Waiver NHTD Waiver LTHHCP
 OMH OMRDD Consumer Directed/PCS CHHA
 Office for the Aging None Other: _____

RRDS Name/Signature: _____ Date: _____

