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**: BUFFALO

Applicant Information

Current Telephone: (___) _____

Medicaid Active: ☐ Yes ☐ No ☐ Unknown CIN#

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: ☐ In-state ☐ Out of State
Transitioning from: ☐ 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 #**

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

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:

☐ Nursing Home	☐ Adult Home/Assisted Living	☐ Criminal Justice
☐ Hospital	☐ Medical Personnel	☐ Community Based Services
☐ MDS data	☐ Physical Rehab. Facility	☐ Other: _____
☐ Independent Living Center	☐ Psychiatric Facility	
☐ Local Department of Social Services	☐ Substance Abuse Rehab. Facility	

Provider Contact/Title:_____ Email:_____

Formal Referral Comments: _____

How did the referral source learn about the waiver?

☐ RRDC	☐ Local Department of Social Services	☐ Psychiatric Facility
☐ Nursing Home	☐ Home Care Agency	☐ Substance Abuse Rehab. Facility
☐ Hospital	☐ Medical Personnel	☐ Media (TV, Radio, Newspaper)
☐ Point of Entry	☐ Staff from other waiver	☐ Pamphlets
☐ Independent Living Center	☐ Physical Rehab. Facility	☐ 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:_____

Comments