**REFERRAL FORM**

**HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER**

[ ]  **Nursing Home Transition (NHTD)** [ ]  **Nursing Home Diversion (NHTD)**

[ ]  **Traumatic Brain injury Transition (TBI)** [ ]  **Traumatic Brain injury Diversion (TBI)**

[ ]  **Out-of-State**

|  |  |  |  |
| --- | --- | --- | --- |
| **Prefix** | **First Name** | **Last Name** | **Referral #** |
| Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text.(Leave blank, assigned by software program - Date YYYYMMDD + Region number + R + referral counter, Ex. 20181016-02-R012) |
| RegionChoose an item. | CIN Click or tap here to enter text. | Medicaid Status:Choose an item. | ***Actions*** | ***Dates*** |
|  |  |  | Initial Referral | Click or tap to enter a date. |
|  |  |  | Initial Contact | Click or tap to enter a date.  |
| **Applicant Address/Location** |
| Applicant Address 1Click or tap here to enter text. |
| Applicant Address 2Click or tap here to enter text. |
| City Click or tap here to enter text. | ZipClick or tap here to enter text. |
| Applicant Telephone:Click or tap here to enter text. | Applicant Email:Click or tap here to enter text. |
| Current Location: Choose an item. | If facility resident, facility name:Click or tap here to enter text. | Type of Location: Choose an item. |
| Other Location Description: Click or tap here to enter text. |
| Is the mailing address the same as physical address: Choose an item. |
| **Applicant Mailing Address, if different** |
| Mailing Address (check all that apply): [ ]  Current [ ]  Legal  |
| Facility NameClick or tap here to enter text. |
| Address Line1Click or tap here to enter text. |
| Address Line2Click or tap here to enter text. |
| CityClick or tap here to enter text. | ZipClick or tap here to enter text. |
| **Applicant Information** |
| [ ]  Check box if applicant requires a translator/interpreter  | If checked, specify primary language:Click or tap here to enter text. |
| Describe reason for referral: Click or tap here to enter text. |
| Applicant Birth Date (if known):Click or tap to enter a date. | Applicant Sex:Choose an item. | Marital Status:Choose an item. |
| **Referral Source** |
| Referral Source Name/Provider Contact: Click or tap here to enter text. |
| Address Line1Click or tap here to enter text. |
| Address Line2Click or tap here to enter text. |
| CityClick or tap here to enter text. | Zip:Click or tap here to enter text. |
| Telephone Number:Click or tap here to enter text. | Email:Click or tap here to enter text. |
| Referral Source Type (select one from drop-down list):Choose an item. | If Family Referral, Relationship to ApplicantClick or tap here to enter text. |
| If “Other (specify)” is chosen as the referral source, describe:Click or tap here to enter text. |
| Is the referral source the court Appointed Legal Guardian:Choose an item. | Is address same as applicant?: Choose an item. |
| Comments:Click or tap here to enter text. |
| **Outcomes – this section to be completed by the RRDC** |
| ***Referral Status*** |  | ***Dates*** |
| [ ]  Proceed to Intake |  |  |
| [ ]  Referred to Region  | Region name: Choose an item. | Click or tap to enter a date. |
| [ ]  Closed, Notice of Decision Denial of Waiver Program issued. | If closed, reason: Choose an item.Other Click or tap here to enter text. | Click or tap to enter a date. |
| Referral made to other resource(s): [ ]  SPOA [ ]  OMH [ ]  CHHA[ ]  CDPAS/PCS [ ]  OPWDD [ ]  Open Doors[ ]  Office for the Aging [ ]  Managed Care [ ]  None [ ]  Other |
| Describe “Other” Referral Source: Click or tap here to enter text. |
| **Person Completing the Form Signatures** |
| Name of person taking the referralClick or tap here to enter text. | Date:Click or tap to enter a date. |
| Comments:Click or tap here to enter text. |