**INTAKE FORM**

**HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER**

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

**Traumatic Brain injury Transition (TBI)**  **Traumatic Brain injury Transition (TBI)**

**Out-of-State**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Prefix** | **Applicant First Name** | | | | | | | | **Last Name** | | | **Region** | | | |
| Choose an item. | Click or tap here to enter text. | | | | | | | | Click or tap here to enter text. | | | Choose an item. | | | |
| Referral #  Click or tap here to enter text. | | | | | | | | | | | | CIN  Click or tap here to enter text. | | | |
| **Action Taken** | | | | | | | | | | | | **Date of Action** | | | |
|  | | | | | | | Referral to RRDC | | | | | Click or tap to enter a date. | | | |
|  | | | | | | | Contacted by RRDC | | | | | Click or tap to enter a date. | | | |
| Note: use the intake schedule history to record all scheduled dates in comma separated format and chronological order, including first and last(e.g. 1/2/2019, 1/15/2019, 2/1/2019) | | | | | | | Intake Schedule History | | | | | Click or tap here to enter text. | | | |
| **Applicant Residence Address** | | | | | | | | | | | | | | | |
| Applicant Address 1  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Applicant Address 2  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| City  Click or tap here to enter text. | | | | | | | | | | | | Zip  Click 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, name of facility:  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 Name  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Address Line1  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Address Line2  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| City  Click or tap here to enter text. | | | | | | Zip  Click or tap here to enter text. | | | | | | | | | |
| **Applicant Information** | | | | | | | | | | | | | | | |
| If living in the community, person/people currently living with (check all that apply):  Alone  Spouse  Adult Children  Minor Children  Parents  Siblings  Other Family Members  Friends/Significant Others  Other  Specify Other Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Applicant requires a translator/interpreter | | | | | | | | | | | | | | | |
| If checked, specify language:  Click or tap here to enter text. | | | | | If yes, translation/interpretation provided by:  Click or tap here to enter text. | | | | | | | | | | Translator Telephone:  Click or tap here to enter text. |
| Comments: 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 Line1  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Address Line2  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| City  Click 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 Applicant  Click or tap here to enter text. | | | | | | | |
| If other referral source, describe:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Comments:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Diagnosis:** | | | | | | | | | | | | | | | |
| Reported Primary Diagnosis Associated with Waiver Eligibility:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Onset of Needs Occurred Within:Choose an item. | | | | | | | | | | | | | | | |
| Population category (check all that apply)  Senior (65+)  Physical Disability (18-64)  TBI  IDD | | | | | | | | | | | | | | | |
| If TBI applicant, age of onset:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Legal Guardian/Relevant Informal Support Contact Information:** | | | | | | | | | | | | | | | |
| Court Appointed Legal Guardian:  Choose an item. | | | | | | Relationship to Applicant:  Click or tap here to enter text. | | | | | | | | | |
| Name:  Click or tap here to enter text. | | | | | | Is Guardian address same as applicant?: Choose an item. | | | | | | | | | |
| Telephone:  Click or tap here to enter text. | | | | | | Email:  Click or tap here to enter text. | | | | | | | | | |
| Address Line1  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Address Line2  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| City  Click or tap here to enter text. | | | | | | Zip  Click or tap here to enter text. | | | | | | | | | |
| **Community Living Arrangements, if different from current address:** | | | | | | | | | | | | | | | |
| Proposed Region:  Choose an item. | | | | | | Proposed County:  Choose an item. | | | | | | | | | |
| Address Line1  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Address Line2  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| City  Click or tap here to enter text. | | | | | | Zip  Click or tap here to enter text. | | | | | | | | | |
| Type of community residence: Choose an item.  Other type of community residence description: Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Comments: Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Insurance:** | | | | | | | | | | | | | | | |
| Community Based Medicaid Status: Choose an item. | | | | Medicare # (if applicable):  Click or tap here to enter text. | | | | | | | | County of Fiscal Responsibility:  Choose an item. | | | |
| Check if applicant is a Veteran:  Other Insurance Plan: Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Intake Status** | | | | | | | | | | | | | | | |
| Transfer to different RRDC Region: | | | | | | | | | | | RRDC Region:  Choose an item. | | | | |
| Comments: Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Applicant appears to meet waiver criteria | | | | | | | | | | | | | | | |
| Does not appear to meet waiver criteria due to:(check all that apply): | | | | | | | | | | Level of Care  Death  Age  Not MA eligible  Participant Choice  Unable to Safely Serve  Unable to meet Intake within required time frame  Other: Describe: Click or tap here to enter text. | | | | | |
| Notice of Decision – Denial of Waiver Program – Issued (Enter Date): Click or tap to enter a date. | | | | | | | | | | | | | | | |
| Referral made to other resource(s):  SPOA  OMH  OPWDD  CDPAS/PCS  CHHA  Open Doors  Managed Care  None  Office for the Aging  Other(s):  Other referral Source: Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Forms Checklist** | | | | | | | | | | | | | | | |
| Waiver Initiative Form…………………………………………. Date: Click or tap to enter a date.  Release of Information………………………………………... Date: Click or tap to enter a date.  Initial Applicant Interview and Acknowledgement…………...Date: Click or tap to enter a date.  Freedom of Choice……………………………………………...Date: Click or tap to enter a date.  Application for Participation…………………………………….Date: Click or tap to enter a date.  SC Agency Provider List….…………………………………….Date: Click or tap to enter a date.  Complaint Protocols…………………………………………….Date: Click or tap to enter a date. | | | | | | | | | | | | | | | |
| Does the applicant have an existing LOC assessment? | | | | | | | | | | | | | | | |
| PRI/SCREEN | | | Completed Date: Click or tap to enter a date. | | | | | | | | | | RUG Score: Click or tap here to enter text. | | |
| UAS-NY | | | Completed Date Click or tap to enter a date. | | | | | | | | | | LOC Score: Click or tap here to enter text. | | |
| Intake completed by:  \_\_Click or tap here to enter text.\_\_\_\_\_Click or tap here to enter text.\_\_\_\_\_\_\_\_\_\_\_Click or tap to enter a date. \_\_\_  (Name) (Title) (Date) | | | | | | | | | | | | | | | |
| Describe the current community supports available to the applicant:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Based on information garnered at the intake meeting, the applicant expresses the following choices, needs and challenges:Click or tap here to enter text. | | | | | | | | | | | | | | | |
| The RRDC recommends that the following services be considered in the development of the service plan:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Person Entering the Intake Form into the Database** | | | | | | | | | | | | | | | |
| Name:  Click or tap here to enter text. | | | | | | | | | | | | | | | Date:  Click or tap to enter a date. |
| Comments:  Click or tap here to enter text. | | | | | | | | | | | | | | | |