**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) | |
| Region  Choose 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 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, 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 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** | | | | | | | |
| 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 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 (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 referral  Click or tap here to enter text. | | | | | | Date:  Click or tap to enter a date. | |
| Comments:  Click or tap here to enter text. | | | | | | | |