## REFERRAL FORM

### HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

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

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<table>
<thead>
<tr>
<th>Transferred from: ___________________________</th>
<th>Referral #: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>(RRDS Region)</td>
<td>(Date YYYYMMDD + Region number + R + referral counter, Ex: 20061015-02-R012)</td>
</tr>
</tbody>
</table>

### Applicant Name:

- [ ] Mr. [ ] Mrs. [ ] Ms.

(First/MI/Last/Generational Suffixes)

### Date of Initial Referral: ________________  Region: ________________

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### 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:
  - [ ] 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: (   )

- Does applicant require written materials in alternative formats? [ ] Yes [ ] No

- Specify: ___________________________

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### 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: (   )

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April 2008
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 1-2 years □ last 3-6 months
□ last 2-5 years □ last 6-12 months □ 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: ___________________________
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: __________