MEDICAID WAIVER CLIENT REFERRAL FORM

REFERRAL DATE: _____ CLIENT'S PHONE: _____
(required)
CLIENT'S NAME: _____ □ MALE □ FEMALE
(required)
ADDRESS: _____ CITY _____ ZIP: _____
(required)
COUNTY OF RESIDENCE: _____ DOB: _____
(required)
CLIENT IS AT: □HOME □HOSPITAL □OTHER MEDICAID#: _____

MEDICARE #: _____ SOCIAL SECURITY #: _____

CONTACT PERSON: _____ RELATIONSHIP TO CLIENT: _____
Contact phone number: _____
DIRECTIONS TO CLIENT'S RESIDENCE: _____
_____
_____
_____

REFERRAL SOURCE: _____ PHONE: _____
(required)
PHYSICIAN: _____ PHONE: _____
(primary care required)
ADDRESS: _____ CITY: _____ ZIP: _____

DIAGNOSIS: _____
(diagnosis required)
DIET: _____

SERVICES NEEDED: □In-Home Respite □Institutional Respite □Adult Day Care □Home Health
□Personal Care Service (PCS) □Home Delivered Meals □Non Emergency Transportation (NET)□ other/list

CURRENT SERVICES/PROVIDERS IN PROGRESS: (required)

Discipline	Frequency	Provider

Deficits in ADL's (required)
□Eating
□Toileting
□Bathing
□Personal Hygiene
□Ambulation
□Transferring
□Dressing

ADDITIONAL PERTINENT INFORMATION/SPECIAL NEEDS: _____
_____
_____
_____

For office use only: **Estate Recovery Explained:** □Yes □No

Verification of Medicaid status: □Yes □No Date: _____ Lock in Status: _____
Date Referral Received: _____ Date Client Contacted: _____ By Whom: _____

Please complete each blank/client/Beneficiary must require a nursing facility level of care.