MEDICAID WAIVER CLIENT REFERRAL FORM

REFERRAL DATE: ___________________CLIENT'S PHONE: ____

CLIENT'S NAME: ____ □ MALE □ FEMALE

ADDRESS: ____CITY______________________ZIP: __________

COUNTY OF RESIDENCE: ____DOB: ______________________

CLIENT IS AT: □HOME □HOSPITAL □OTHER MEDICAID#: _______________________________________

MEDICARE #: _________________________________ SOCIAL SECURITY #: ______________________________

CONTACT PERSON: __________________________________ RELATIONSHIP TO CLIENT: __________________

DIRECTIONS TO CLIENT'S RESIDENCE:
____
____
____

REFERRAL SOURCE: ______________________________________ PHONE: ___________________________

PHYSICIAN: ____ PHONE: ___________________________

ADDRESS: ___________________________________CITY: _______________________ ZIP: _______________

DIAGNOSIS: ____

DIET: ____

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

CURRENT SERVICES/PROVIDERS IN PROGRESS:

Discipline	Frequency	Provider

Deficits in ADL's
□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: ____________________

Revised October 15, 2024