**DHS Referral Form**

This form is used to refer clients to Independent Provider (IP), Personal Choice, Shared Living, Office of Healthy Aging, Medicaid Preventive (RIPIN) and other interagency and community programs.

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| **Section I: Referral Information** |
| **Today’s Date**: Click here to enter text. |  |
| **Name of Referrer (*LTSS SCW*):** Click here to enter text. | **Phone #** Click here to enter text. |
| **Referral to:** [ ]  **Office of Healthy Aging** [ ]  **Independent Provider** [ ]  **Shared Living**[ ]  **Personal Choice**[ ]  **Medicaid Preventive (RIPIN)**[ ]  **Other:** Click to Specify |

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| --- |
| **Agency Name:** Click here to enter text. |
| **Worker Name:** Click here to enter text. |
| **Telephone:** | Click here to enter text. |
| **Fax:** | Click here to enter text. |

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| **Section II: Client Information** |
| *Please check all that apply*[ ] Client was found Eligible for Preliminary review and is pending Full eligibility Screening[ ] Client is active on Medicaid however needs to apply for LTSS[ ] Client is active with MCO: Specify MCO here |
| **Client’s Name:** Click here to enter text. | **Phone #:** Click here to enter text. |
| **DOB:** Click here to enter text. | **SSN:** Click here to enter text. | **MID:** Click here to enter text. |
| **Address:** Click here to enter text. |
| **Primary Language**: Click here to enter text. | **Interpreter needed**: [ ] Yes [ ] No |
| **Power of Attorney or Authorized Rep:**Click here to enter text. | **Relationship:**Click here to enter text. | **Phone:** Click here to enter text. |
| **Power of Attorney or Authorized Rep Address:** Click here to enter text. |
| **Section III: DHS Actions** |
| [ ] **Person Centered Options Counseling | Date:**  Click here to enter text.[ ] **Mailed client packet** | **Date**: Click here to enter text.[ ] **Mailed client a “No Response” letter with packet** | **Date:** Click here to enter text.[ ] **Provided Application Assistance** |**Date**: Click here to enter text.[ ] **Pending ADR**. | **Documents needed** Click here to enter text.[ ] **Faxed PM-1 | Date:** Click here to enter text.[ ] **Completed Functional Assessment | Date:** Click here to enter text.[ ] **Processing Program Change** | **Date received**: Click here to enter text.[ ] **Finalized Eligibility [see attached HCBS-2] | Date:** Click here to enter text.**Comments**: Click here to enter text. |
| **Section IV: Case Follow-up** *action required by client and/or community agency* |
| [ ] Case **is a *New* LTSS Request**[ ] Case **is a *Program Change F*rom**  program type to program type**Client needs:**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ] DHS 2 | [ ]  Functional assessment/ UCAT | [ ] DHS 25 | [ ]  CP12 |
| [ ] Blank Renewal | [ ]  PM-1  | [ ] DHS 25M | [ ] Other: Click or tap here to enter text. |

**Additional Client Notes** : Click here to enter text. |