**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 | | |  |  | | --- | --- | | **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. | | | |
| **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. | | | | |