Office of Community Programs
Section Q Referral / Nursing Home Transition Referral Form
Phone: 462-6393 Fax: 462-4266

Today's Date: _____
Name of Nursing Home: _____ Phone: _____
Name of Person Submitting form: _____

Is this referral in response to MDS Section Q: □ Yes □ No

Please indicate reason for referral:
□ *Information Only (pg 1 only)*
□ *Interest in Transition (pg 1 &2)*

Individual's Name: _____ DOB: _____ SSN: _____

Primary Language:_____ Interpreter Needed: □ Yes □ No

Has the Individual experienced chronic homelessness? □ Yes □ No
Is the Individual a Veteran? □ Yes □ No

Name of Health Insurer: _____ Secondary Insurer: _____
Is the primary payer PACE (Program of All-Inclusive Care for the Elderly)? □ Yes □ No
Does the Individual have Long Term Care Medicaid? □ Yes □ No
If not:
Has Individual applied for Long Term Care Medical Assistance (MA)? □ Yes □ No
If yes, when was application submitted? _____
Where was the application submitted? _____
If no, is the family or Social Worker aware of the need to submit the application? □ Yes □ No
Please explain: _____
Is Individual anticipating applying for MA in the future? □ Yes □ No

Diagnosis: _____ BIMS Score: _____
What would the Individual's care planning needs be if they were to be discharged?
□ Skilled Nursing □ PT/OT □ DME □ Lifeline □ Adult Day □ Med Mgmt
□ Assisted Living □ MOW (Meals on Wheels) □ CNA/Homemaking
Is the Individual in need of 24 hour supervision? □ Yes □ No

Is there documentation supporting that a transition to the community would not be appropriate for this Individual?
□ Yes □ No Additional Comments:_____
_____
Does Individual have a Legal Guardian or Power of Attorney? □ Yes □ No
If yes, provide: Name: _____ Phone: _____
Has family or guardian been notified of referral? □ Yes □ No □ N/A
Guardian: Address _____Apt#: _____Floor:_____ City/Town: _____
Zip:_____ Telephone Number:_____

Anticipated D/C Date:_____ **NH D/C Planner Name:_____**

Admission Date: _____ Reason for Admission: _____

If the sole reason for admission was for short-term rehab, what is/was the last Medicare covered day for short-term rehab? Date: _____

Admitted from: □ Hospital □ Assisted Living □ Home □ Rehab Facility □ Other _____

Recent Hospitalizations: □ Yes □ No. If yes, provide name of Hospital: _____
Reason for Hospitalization: _____

Did the Individual receive services in the community prior to this admission? □ Yes □ No
If yes, provide agency name and services received: _____
_____

Does the Individual have or had a case worker with Department of Elderly Affairs (DEA) or Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) or Long Term Care (LTC)? □ Yes □ No
If yes, which agency □ DEA □ BHDDH □ LTC Case Worker Name if known:_____

Date and outcome of most recent PASRR determination:_____

Does the Individual have a family support system? □ Yes □ No Please explain _____

Will Individual be: □ Living alone □ With others □ Need housing assistance
Please describe _____

If known, please provide the Individual's community address: □ rent □ own
Address _____Apt#: _____Floor:_____ City/Town: _____
Zip:_____ Telephone Number: _____

Spouse Name, if applicable:_____
Primary Contact: _____ Relationship:_____ Contact Phone:_____
Address:_____ City/Town:_____ State:____ Zip:_____

Have you referred this Individual to the Nursing Home Team previously? □ Yes □ No
If yes, have there been any changes that would now make a transition more appropriate? □ Yes □No
Please describe: _____