Medicaid Office of Community Programs
Nursing Home Transition Program Referral Form

Telephone: 401-462-6393 Fax: 401-462-4266 E-mail: ohhs.ocp@ohhs.ri.gov

To make a referral: Complete this form and fax it to the number listed above. You may also call the telephone number above to make a referral.

Nursing Homes: Please include the most recent documentation requested below. Check documents attached.

☐ ***Face Sheet*** ☐ ***MD Orders*** ☐ ***MD Note*** ☐ ***Nursing Notes*** ☐ ***PT/OT Notes*** ☐ ***Psychiatric Notes***

☐ ***MDS*** ☐ ***Social Work Notes***

Referral date:_____ Name of nursing home: _____

Name of person submitting referral:_____ Phone: _____

Agency or relationship to referred individual:_____

Is this referral submitted in response to the MDS Section Q: ◯ Yes ◯ No

Individual's name:_____ DOB:_____ SSN:_____

Telephone no.:_____ Can the person be contacted in facility at this number? ◯ Yes ◯ No

Primary Language:_____ Interpreter Needed: ◯ Yes ◯ No

Has the Individual experienced chronic homelessness? ◯ Yes ◯ No

Is the Individual a Veteran? ◯ Yes ◯ No

Primary health insurer:_____ Secondary health insurer: _____

Does the individual have Long Term Care Medicaid? ◯ Yes ◯ No

If not, has the individual applied for Long Term Care Medical Assistance? ◯ Yes ◯ No

If yes, when was application submitted? _____

If individual has not applied, does he/she plan to apply? ◯ Yes ◯ No

Diagnoses/Health conditions:

BIMS Score: _____

What are the person's care planning needs? ☐ Skilled Nursing ☐ PT/OT ☐ DME ☐ Adult Day Program

☐ Personal Emergency Response ☐ Medication Management ☐ Home Delivered Meals ☐ Assisted Living

☐ CNA/Homemaking

Does the individual require 24-hour supervision? ◯ Yes ◯ No

Is there documentation supporting that transition to the community is not appropriate for this person? ◯ Yes ◯ No

Comments:

Does the individual have a Legal Guardian? ◯ Yes ◯ No Power of Attorney? ◯ Yes ◯ No

If yes, name:_____ Phone:_____

Is guardian aware of referral? ◯ Yes ◯ No

Is family aware of referral? ◯ Yes ◯ No

Anticipated discharge date:_____ Admission date: _____

Reason for admission: _____

If part of stay was covered by Medicare, when is/was the last Medicare covered day? _____

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

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 has he/she had, a case worker with Department of Elderly Affairs (DEA), Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), or Department of Human Services Long Term Care (LTC)? ◯ Yes ◯ No If yes, which agency? ◯ DEA ◯ BHDDH ◯ LTC

Case worker name, if applicable: _____

Does the individual receive case management support from a community agency? ◯ Yes ◯ No

If yes, agency name:_____ Agency phone: _____

PASRR date and outcome (most recent):

Does the person have a family support system? ◯ Yes ◯ No Please describe:

Individual will: ◯ Live alone ◯ Live with others ◯ Need housing assistance Please describe:

If available, individual's community address: ☐ rent ☐ own ☐ home ☐ apartment ☐ assisted living

Street Address_____ Apt#: _____

City/Town:_____ State:_____ Zip: _____

Spouse's name, if applicable: _____

Emergency contact:_____ Relationship: _____

Contact phone:_____ Street address: _____

City/Town: _____ State: _____ Zip: _____