New York State Department of Health
Division of Long Term Care

REFERRAL FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

☐ **Nursing Home Transition (NHTD)** ☐ **Nursing Home Diversion (NHTD)**
☐ **Traumatic Brain injury Transition (TBI)** ☐ **Traumatic Brain injury Diversion (TBI)**

☐ **Out-of-State**

Prefix	**First Name**	**Last Name**	**Referral #**	
Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text. (Leave blank, assigned by software program - Date YYYYMMDD + Region number + R + referral counter, Ex. 20181016-02-R012)	
Region Choose an item.	CIN Click or tap here to enter text.	Medicaid Status: Choose an item.	***Actions***	***Dates***
			Initial Referral	Click or tap to enter a date.
			Initial Contact	Click or tap to enter a date.

Applicant Address/Location		
Applicant Address 1 Click or tap here to enter text.		
Applicant Address 2 Click or tap here to enter text.		
City Click or tap here to enter text.		Zip Click or tap here to enter text.
Applicant Telephone: Click or tap here to enter text.		Applicant Email: Click or tap here to enter text.
Current Location: Choose an item.	If facility resident, facility name: Click or tap here to enter text.	Type of Location: Choose an item.
Other Location Description: Click or tap here to enter text.		
Is the mailing address the same as physical address: Choose an item.		

Applicant Mailing Address, if different		
Mailing Address (check all that apply): ☐ Current ☐ Legal		
Facility Name Click or tap here to enter text.		
Address Line1 Click or tap here to enter text.		
Address Line2 Click or tap here to enter text.		
City Click or tap here to enter text.		Zip Click or tap here to enter text.

Applicant Information		
☐ Check box if applicant requires a translator/interpreter		If checked, specify primary language: Click or tap here to enter text.
Describe reason for referral: Click or tap here to enter text.		
Applicant Birth Date (if known): Click or tap to enter a date.	Applicant Sex: Choose an item.	Marital Status: Choose an item.
Referral Source		
Referral Source Name/Provider Contact: Click or tap here to enter text.		
Address Line1 Click or tap here to enter text.		
Address Line2 Click or tap here to enter text.		
City Click or tap here to enter text.		Zip: Click or tap here to enter text.
Telephone Number: Click or tap here to enter text.		Email: Click or tap here to enter text.
Referral Source Type (select one from drop-down list): Choose an item.		If Family Referral, Relationship to Applicant Click or tap here to enter text.
If "Other (specify)" is chosen as the referral source, describe: Click or tap here to enter text.		
Is the referral source the court Appointed Legal Guardian: Choose an item.		Is address same as applicant?: Choose an item.
Comments: Click or tap here to enter text.		
Outcomes – this section to be completed by the RRDC		
Referral Status		***Dates***
☐ Proceed to Intake		
☐ Referred to Region	Region name: Choose an item.	Click or tap to enter a date.
☐ Closed, Notice of Decision Denial of Waiver Program issued.	If closed, reason: Choose an item. Other Click or tap here to enter text.	Click or tap to enter a date.
Referral made to other resource(s): ☐ SPOA ☐ OMH ☐ CHHA ☐ CDPAS/PCS ☐ OPWDD ☐ Open Doors ☐ Office for the Aging ☐ Managed Care ☐ None ☐ Other		
Describe "Other" Referral Source: Click or tap here to enter text.		
Person Completing the Form Signatures		
Name of person taking the referral Click or tap here to enter text.		Date: Click or tap to enter a date.
Comments: Click or tap here to enter text.		