Vermont Department of Disabilities, Aging and Independent Living

VERMONT

Section Q and Nursing Home Transition Referral Form: Final October 2013

Instructions: Please complete this form for **ALL INDIVIDUALS** who answer "yes" to the MDS 3.0 Question Q0500B and for all individuals who express a desire to transition out of a nursing home, **regardless of whether this request was part of the MDS 3.0 assessment**. Such a request may be made outside of a formal MDS assessment and should be referred to the Local Contact Agency for Options Counseling.

All referrals must be e-mailed via SECURE email or if not secure, via fax, to the contact e-mail and fax numbers listed below. For individuals age 60 and over, please refer to your local Area Agency on Aging by selecting from the list below. For individuals under age 60, please refer to the Vermont Center for Independent Living from the list below.

Area Agency on Aging for age 60 and over:

Vermont Center for Independent Living for under age 60:

Consumer Referral Information (All fields are required.)

Date of Referral:

Nursing Home Making Referral: Please select from the list below.

First Name of Staff Making Referral:

Last Name of Staff Making Referral:

Email Address of Staff Making Referral:

Phone Number of Staff Making Referral:

Fax Number for Staff Making Referral:

Other Referral Source if not the Nursing Home: Please select from the list below.

Individual's/Resident's First Name:

Individual's/Resident's Last Name:

Individual's/Resident's Date of Birth:

Individual's/Resident's Town of Residence: Please select from the list below.

Medicaid Number: Please insert 14-digit number below.

Nursing Home Date of Admission:

Next of kin/primary point of contact or guardian: Please select from list below.

Does the individual have a brain injury?

Yes No

Individual's Primary Disability (from MDS 3.0): Please select from list below.

Is the individual on Choices for Care?

Yes No

If the individual is enrolled in Choices for Care, does the individual have a case manager?

Yes, AAA Yes, HHA No

Individual's Payor Source:

Medicare Medicaid Private insurance Private Pay

Individual identified a barrier to transitioning back to the community:

Yes No

If yes, please select type of barrier from the list below: Please select as many as appropriate.

Housing Support services Household goods Medical equipment

Special accommodations needed by individual to communicate: Please select as many as necessary.

None

Interpreter

Large print/Braille

Support person for cueing/prompts

Other

For Local Contact Agency Use Only: Please indicate Date Referral Received.