



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 DIVISION OF SENIOR AND DISABILITY SERVICES
HOME AND COMMUNITY SERVICES REFERRAL

DATE

PERSON BEING REFERRED (LAST, FIRST, MI)	DOB	DCN	SSN	RACE/SEX
ADDRESS (STREET, CITY, ZIP)		COUNTY	PHONE NUMBER(S)	
NAME OF PERSON MAKING REFERRAL		RELATIONSHIP	PHONE NUMBER(S)	

ADDRESS (STREET, CITY, ZIP)	REASON FOR REFERRAL <input type="checkbox"/> In-home Services <input type="checkbox"/> RCF-Personal Care <input type="checkbox"/> Consumer-Directed Services
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OTHER PERSONS INVOLVED	ROLE	ADDRESS	PHONE
	Physician		
	Contact		
	Other		

REFERRAL INFORMATION	REMARKS/EXPLANATION
Does person have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Use telephone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
See physician? (MON) <input type="checkbox"/> Yes <input type="checkbox"/> No (Include Medical Condition and Frequency)	
Follow medical directions? (MON) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Receive home health? (MON) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have prescribed medications? (MEDS) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Receive physician-ordered treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Receive restorative (teaching/training) services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Receive physician-ordered therapy? (REHAB) <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST	
Personal Care Needs: <input type="checkbox"/> Grooming <input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Bowel Program <input type="checkbox"/> Catheter <input type="checkbox"/> Ostomy	
Dietary Needs: <input type="checkbox"/> Special Diet <input type="checkbox"/> Preparation <input type="checkbox"/> Assist w/eating <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Shopping	
Mobility Needs: <input type="checkbox"/> Human Assistance <input type="checkbox"/> Cane/walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Lift (type) <input type="checkbox"/> Other	
Cognitive Issues: <input type="checkbox"/> Disoriented <input type="checkbox"/> Wanders <input type="checkbox"/> Depression <input type="checkbox"/> Alzheimers <input type="checkbox"/> Poor Memory <input type="checkbox"/> Diagnosed MI/MR/DD <input type="checkbox"/> Comatose <input type="checkbox"/> Guardian/Conservator/Power of Attorney	
Behavior Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No (Describe)	
Potential danger? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mental Health History <input type="checkbox"/> History of Violent Behavior <input type="checkbox"/> Weapons in home <input type="checkbox"/> Drug House <input type="checkbox"/> Vicious Dog(s) <input type="checkbox"/> Other	

DIRECTIONS TO LOCATE – COMMENTS:

DHSS USE ONLY										
PRELIMINARY LOC	MON	MEDS	TRTS	REST	REHB	PC	DIET	MOB	BEH	LOC
										0
MEDICAID STATUS	<input type="checkbox"/> Active <input type="checkbox"/> Applied <input type="checkbox"/> Spenddown <input type="checkbox"/> Not Eligible									
CLOSING CODE										