APS-PCCP COORDINATION

Send form to the following email address once completed:
HCBSIntakeAndPCCP@health.mo.gov

ASSIGNED APS WORKER	
NAME: **CONTACT NUMBER:**	
PERSON BEING REFERRED (LAST, FIRST, MI)	**DCN:**
PARTICIPANT'S CURRENT HOME ADDRESS	
STREET **APT. / FLOOR** **CITY, STATE, ZIP** **COUNTY**	
PRIMARY TELEPHONE NUMBER	**ALTERNATE TELEPHONE NUMBER**
REASON FOR REFERRAL	☐ **PROVIDER CHANGE** ☐ **CARE PLAN CHANGE** **OTHER (explain):**
SAFETY CONCERNS	☐ **NO KNOWN CONCERNS** ☐ **ILLEGAL DRUG ACTIVITY** ☐ **WEAPONS IN THE HOME** ☐ **HISTORY OF VIOLENT BEHAVIOR** ☐ **DANGEROUS NEIGHBORHOOD** ☐ **CONTAGIOUS/ INFECTIOUS DISEASE** ☐ **PEST INFESTATION** ☐ **STRUCTURALLY UNSAFE HOME** ☐ **OTHER: EXPLAIN BELOW**
OTHER RESPONSIBLE PARTY/ LEGAL GUARDIAN CONTACT NAME:	
RELATIONSHIP/ AFFILIATION: (SELECT ALL THAT APPLY)	
☐ **FAMILY MEMBER** ☐ **LEGAL GUARDIAN** ☐ **PUBLIC ADMINISTRATOR** ☐ **DURABLE POWER OF ATTORNEY/ POWER OF ATTORNEY** ☐ **OTHER:**	
PRIMARY PHONE NUMBER	**ALTERNATE NUMBER**
ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**

Do not upload to Web Tool Please upload the form to:
Shared O: > Regional Assessments > APS and Legislative Referrals

ADDITIONAL DETAILS: