



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

****Applied for HCBS in last 90 days**

Yes No
 If Yes, please document change in condition or circumstances under UNMET NEEDS SECTION.

ALL FIELDS REQUIRED - Return Form to: HCBSCallCenterReferrals@health.mo.gov
 Upon receipt of completed referral, DSDS will contact all necessary parties to continue process. HCBS providers can check Cyber Access Web Tool for status updates.

PERSON BEING REFERRED (LAST, FIRST, MI)	DCN	DOB (MM/DD/YYYY)
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PHYSICAL ADDRESS: STREET:	APT./LOT
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CITY:	ZIP:	COUNTY:
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MAILING ADDRESS: P.O. BOX/STREET:	SAME AS PHYSICAL <input type="checkbox"/> Yes <input type="checkbox"/> No
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CITY:	STATE:	ZIP:
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PRIMARY PHONE NUMBER:	ALTERNATE PHONE NUMBER:
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CONTACT OTHER RESPONSIBLE PARTY/GUARDIAN TO SCHEDULE ASSESSMENT:
 Yes No

OTHER RESPONSIBLE PARTY/LEGAL GUARDIAN CONTACT NAME:

RELATIONSHIP/AFFILIATION: (SELECT ALL THAT APPLY)
 Family Member Legal Guardian Durable Power of Attorney/Power of Attorney
 Public Administrator Other _____

PRIMARY PHONE NUMBER:	ALTERNATE PHONE NUMBER:
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ADDRESS:

CITY:	STATE:	ZIP:
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COMMUNICATION NEEDS

PRIMARY LANGUAGE:	INTERPRETER NEEDED:
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IF YES, WHAT LANGUAGE?

OTHER COMMUNICATION NEEDS:

HOSPITAL/FACILITY:

IS THE PERSON BEING REFERRED CURRENTLY IN A HOSPITAL/FACILITY? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES: EXPECTED DISCHARGE DATE (MUST BE WITHIN 15 DAYS):
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NAME/ADDRESS OF HOSPITAL/FACILITY:

POINT OF CONTACT AT HOSPITAL/FACILITY:

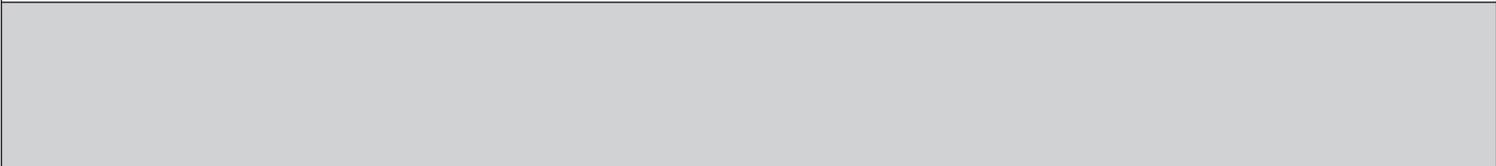
PHONE NUMBER:

MARITAL STATUS/LIVING ARRANGEMENTS:

Never Married Married Separated Divorced Widowed

RCF/ALF: <input type="checkbox"/> Yes <input type="checkbox"/> No	LIVE ALONE: <input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO, NUMBER OF ADULTS IN HOUSE:
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ANY OTHER HOUSEHOLD MEMBER(S) RECEIVING OR REQUESTING SERVICES:
 Yes No



PRIMARY MEDICAL CONDITIONS: (RELATED TO THE PERSON'S NEED FOR HOME AND COMMUNITY BASED SERVICES)

UNMET NEEDS OF THE PERSON BEING REFERRED: (SELECT ALL THAT APPLY)

- Adult Day Care Caregiver Relief (Respite) Dietary Essential Transportation Hands-On Personal Care
 Household Cleaning Related Tasks

**DOCUMENT UNMET CONDITIONS AND CIRCUMSTANCES FROM APPLICATION FOR HCBS IN LAST 90 DAYS HERE:

REASON FOR REFERRAL: (SELECT ALL THAT APPLY)

- Adult Day Care Advanced Personal Care Authorized Nurse Visits Home Delivered Meals (Age 63+)
 Homemaker (Age 63+) Independent Living Waiver (Age 18-64) Personal Care (Agency)
 Personal Care (Consumer Directed) Personal Care (RCF/ALF) Respite Care (Age 63+)
 Structured Family Caregiving Waiver

SAFETY CONCERNS: (SELECT ALL THAT APPLY)

- Access to Home Contagious/Infectious Disease Dangerous Neighborhood History of Violent Behavior
 Illegal Drug Activity No Known Concerns Pest Infestation Structurally Unsafe Home
 Vicious or Dangerous Animal/Pet Weapons in the Home Other

PROVIDER AGENCY REFERRAL:

- Yes No

REFERRER NAME:

REFERRER PHONE NUMBER:

REFERRER RELATIONSHIP:

MILITARY SERVICE QUESTION:

- Have you or an immediate family member ever served in the U.S. Armed Forces? Yes No
If YES, would you like information about military-related services in Missouri? Yes No