Missouri Long-Term Care Ombudsman Program
Show-Me Home Referral Form

EMAIL To: SMH@health.mo.gov	
FROM (PLEASE PRINT OR TYPE):	FAX:
PHONE:	DATE:
REFERRAL (COMPLETED BY REGIONAL LTCOP COORDINATOR)	
FACILITY NAME & ADDRESS:	FACILITY TELEPHONE:
RESIDENT'S NAME:	RESIDENT'S DATE OF BIRTH:
RESIDENT'S CONDITION: (ATTACH ANOTHER SHEET IF NEEDED)	RESIDENT'S SSN:
	RESIDENT'S DCN:
	DATE ENTERED SNF:
DISPOSITION (NOTIFY SMH OVERSIGHT STAFF WITHIN **30** DAYS)	
☐ RESIDENT APPROVED FOR SMH	DATE OF ENROLLMENT:
☐ RESIDENT DOES **NOT** MEET ELIGIBILITY REQUIREMENTS - CHECK ALL THAT APPLY. ☐ NOT MEDICAID ELIGIBLE ☐ NO QUALIFIED HOUSING AVAILABLE ☐ GUARDIAN REFUSED PARTICIPATION ☐ RESIDENT NOT IN SKILLED NURSING FACILITY (SNF) FOR 60 DAYS ☐ RESIDENT QUALIFIED BUT NOT APPROVED DUE TO HEALTH AND SAFETY CONCERNS ☐ RESIDENT IN SNF SOLELY FOR THE PURPOSE OF SHORT-TERM REHABILITATION FUNDED BY MEDICARE	
☐ RESIDENT DOES NOT MEET LEVEL OF CARE FOR HOME AND COMMUNITY BASED SERVICES	
SMH/RC NAME and Phone Number:	
COMMENTS (COMMUNITY SUPPORTS, CHALLENGES, ETC.)	
CHECK BOX IF ADDITIONAL PAGES ATTACHED ☐	