ATTACHMENT C
REFERRAL NOTIFICATION

Participant's Name: _____

DCN or DOB: _____

Nursing Facility Admission Date: _____

Check those that apply below:

Options Counseling Services were not provided: _____

Options Counseling Services have been provided but LOC assessment is not indicated: _____

Participant is not interested in transition services: _____

If additional space is needed for explanation (beyond information in the MFP system):

_____

_____

_____

_____

_____

_____

_____

Options Counselor: _____ Date: _____

NOTE: SEND TO THE DSDS MFP REGIONAL COORDINATOR