



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 the electronic case record for status updates.

| | | |
|---|-----|------------------|
| PERSON BEING REFERRED (LAST, FIRST, MI) | DCN | DOB (MM/DD/YYYY) |
|---|-----|------------------|

| | |
|---------------------------|----------|
| PHYSICAL ADDRESS: STREET: | APT./LOT |
|---------------------------|----------|

| | | |
|-------|------|---------|
| CITY: | ZIP: | COUNTY: |
|-------|------|---------|

| | |
|-----------------------------------|--|
| MAILING ADDRESS: P.O. BOX/STREET: | SAME AS PHYSICAL <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-----------------------------------|--|

| | | |
|-------|--------|------|
| CITY: | STATE: | ZIP: |
|-------|--------|------|

| | |
|-----------------------|-------------------------|
| PRIMARY PHONE NUMBER: | ALTERNATE PHONE NUMBER: |
|-----------------------|-------------------------|

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: |
|-----------------------|-------------------------|

ADDRESS:

| | | |
|-------|--------|------|
| CITY: | STATE: | ZIP: |
|-------|--------|------|

COMMUNICATION NEEDS

| | |
|-------------------|---------------------|
| PRIMARY LANGUAGE: | INTERPRETER NEEDED: |
|-------------------|---------------------|

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): |
|--|---|

NAME/ADDRESS OF HOSPITAL/FACILITY:

POINT OF CONTACT AT HOSPITAL/FACILITY:

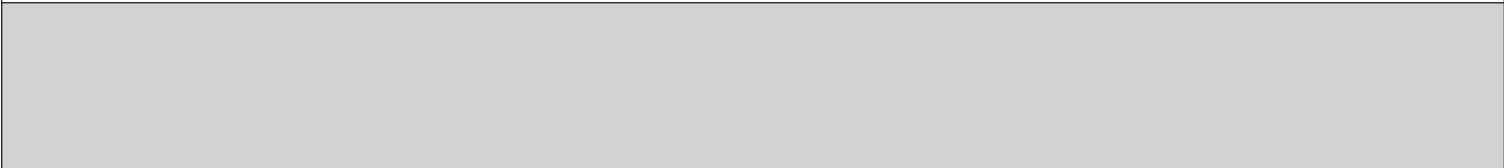
PHONE NUMBER:

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: |
|--|---|-----------------------------------|

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