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) |
|---|---|---|
| | | |

**PHYSICAL ADDRESS:** STREET: APT./Lot

CITY: ZIP: COUNTY:

**MAILING ADDRESS: Same as Physical** ◉ **Yes** ◯ **No**
P.O. BOX/STREET: 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: ◯ YES ◯ NO

IF YES, WHAT LANGUAGE?

OTHER COMMUNICATION NEEDS:

**HOSPITAL/ FACILITY:** IS THE PERSON BEING REFERRED CURRENTLY IN A HOSPITAL/FACILITY?
◯ YES ◯ NO IF YES: EXPECTED DISCHARGE DATE:

NAME/ADDRESS OF HOSPITAL/FACILITY:

POINT OF CONTACT AT HOSPITAL/FACILITY:
NAME:
PHONE NUMBER:

**MARITAL STATUS/LIVING ARRANGEMENTS:**
☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

RCF/ALF: ◯ YES ◉ NO LIVE ALONE: ◯ YES ◉ 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+)

**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: