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/YYY)

PHYSICAL ADDRESS: STREET:	APT./LOT

CITY:	ZIP:	COUNTY:

MAILING ADDRESS: P.O. BOX/STREET:	SAME AS PHYSICAL ☐ Yes ☐ 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? ☐ Yes ☐ 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: ☐ 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+)
☐ 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