MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

HOME AND COMMUNITY BASED SERVICES REFERRAL

DATE

PERSON BEING REFERRED (LAST, FIRST, MI)	DCN	RACE	SEX	DOB (MM/DD/YYYY)

PHYSICAL ADDRESS (STREET, CITY, ZIP)	MAILING ADDRESS (STREET, CITY, ZIP)	COUNTY	PRIMARY PHONE NUMBER	OTHER PHONE

MARITAL STATUS/LIVING ARRANGEMENTS	PRIMARY LANGUAGE	SPECIAL COMMUNICATION NEEDS

REPORTED HEALTH CONDITION

NAME OF PERSON MAKING REFERRAL	AGENCY NAME	PHONE NUMBER(S)

ADDRESS (STREET, CITY, ZIP)

OTHER PERSONS INVOLVED	ROLE	ADDRESS	PHONE
	Physician		
	Other Responsible Party		
	Other		

REASON FOR REFERRAL	☐ PERSONAL CARE ASSISTANCE (CONSUMER-DIRECTED MODEL) ☐ HOMEMAKER ☐ RESPITE CARE ☐ PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY ☐ ADULT DAY CARE ☐ HOME DELIVERED MEALS ☐ PERSONAL CARE ☐ ADVANCED PERSONAL CARE ☐ AUTHORIZED NURSE VISITS ☐ PERSONAL CARE RCF/ALF
SAFETY CONCERNS	☐ NO KNOWN CONCERNS ☐ DANGEROUS NEIGHBORHOOD ☐ ILLEGAL DRUG ACTIVITY ☐ CONTAGIOUS/ INFECTIOUS DISEASE ☐ STRUCTURALLY UNSAFE HOME OR ACCESS TO HOME ☐ WEAPONS IN THE HOME ☐ PEST INFESTATION ☐ HISTORY OF VIOLENT BEHAVIOR ☐ OTHER: EXPLAIN
MEDICAID STATUS	☐ ACTIVE ☐ SPENDDOWN (CHECKED CYBERACCESS WEBTOOL, MEDICAID CURRENTLY ACTIVE? – ☐ YES ☐ NO)

COMMENTS

DIRECTIONS TO PARTICIPANT ADDRESS