

MDS Section Q Community Options and/or Going Home Plus Referral Form

(Check one or both)

MDS SECTION Q **GOING HOME PLUS Project**

Instructions for facilities: Please complete the form below for ALL residents who 1) would like to speak to someone about community options (based on MDS Section Q) and/or 2) are potential Going Home Plus participants

Referral Date: _____		Medicaid <input type="checkbox"/> No <input type="checkbox"/> Yes	
Resident Name: (Last, First, MI) _____			
Medicaid Client ID#: _____ <input type="checkbox"/> AlohaCare <input type="checkbox"/> HMSA <input type="checkbox"/> Kaiser <input type="checkbox"/> Ohana <input type="checkbox"/> UHC			
<input type="checkbox"/> Discharge currently in process		Age: _____	
<input type="checkbox"/> Referral to (Agency/Provider name): _____		Date of Birth: _____	
<input type="checkbox"/> Referral to QI Plan (Contact Name): _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
Facility Name: _____			
Island: <input type="checkbox"/> Oahu <input type="checkbox"/> Maui <input type="checkbox"/> East Hawaii <input type="checkbox"/> West Hawaii <input type="checkbox"/> Kauai <input type="checkbox"/> Other _____			
Facility Contact: _____		Phone Number: _____	Fax Number: _____
Name of resident's Authorized Representative (Last, First) <input type="checkbox"/> Self			
Address of Authorized Representative Mailing Address, City, State and Zip Code: _____			
Primary Diagnosis: _____		Weight: _____	
Nursing Facility Level of Care DHS1147 Expiration Date: _____ DHS1147 Point Total: _____ <input type="checkbox"/> N/A (private pay resident)			
Proposed Living Arrangement (if known): <input type="checkbox"/> Own Home <input type="checkbox"/> Other Family Home <input type="checkbox"/> Other Rental <input type="checkbox"/> Foster Home (CCFFH-EARCH) <input type="checkbox"/> ALF <input type="checkbox"/> Other _____			
# Months institutionalized: _____		Admit date to institution: _____	
Hx and dates if more than one facility:			
1. Admit _____		Transfer _____	Facility _____
2. Admit _____		Transfer _____	Facility _____
3. Admit _____		Transfer _____	Facility _____
FOLLOW UP (To be completed by Local Contact Agency (LCA))			
Name/Agency of LCA Representative: _____			
Date LCA Representative Contacted Resident/Family: _____			
Date LCA Representative Met with Resident/Family: _____			
Date Completed Referral Form Returned to the Facility: _____			

****GOING HOME PLUS ELIGIBILITY:** (1) Medicaid; (2) Approved Level of Care on DHS 1147 or DHS 1150; (3) At least 90 continuous days in a hospital, nursing home, ICF-MRC and or rehab facility (not including Medicare short term rehab days):

Madi Silverman **Phone: 808-692-8166** **FAX: 808-692-8087** **Mail:** P.O. Box 700190 Kapolei, HI 96709-0190
Attach: Facility Face Sheet and Current DHS 1147 form.

FORM PURPOSE

The DHS 1132A, "MDS Section Q Community Options and/ or Going Home Plus Referral" form, shall be used by the interested party to request assistance from the Med-QUEST Division regarding community options (based on MDS Section Q) and/or the Going Home Plus Program.

FORM INSTRUCTIONS

1. The referring facility to complete the following:
 - a. **Referral Date:** Month-XX/Day-XX/Year-XX
 - b. **Medicaid:** Check Yes or No, if the resident being referred has Medicaid.
 - c. **Resident Name:** Enter the resident's Last, First and Middle Initial (MI).
 - d. **Medicaid Client ID#:** Enter the resident's ID number and select the coverage plan they are under.
 - e. **Marital Status:** Select the resident marital status.
 - f. **Facility Name:** Enter the Facility Name.
 - g. **Island:** Select the Island/Region that the Facility is in.
 - h. **Facility Contact:** Enter the Family Contact of the resident Name if applicable.
 - i. **Phone Number:** Enter the Family Contact of the resident phone number if applicable.
 - j. **Fax Number:** Enter the Family Contact of the resident Fax Number if applicable.
 - k. **Name of resident's Authorized Representative:** Enter the Last, First name of the Authorized Representative (if applicable). Select "Self" if there is no authorized representative.
 - l. **Address of Authorized Representative:** Enter the Mailing Address, City, State and Zip Code of the Authorized Representative.
 - m. **Primary Diagnosis:** Enter the Primary Diagnosis of the resident.
 - n. **Weight:** Enter the weight of the resident.
 - o. **Nursing Facility Level of Care:** Enter the DHS 1147 Expiration Date and DHS 1147 point total. Select N/A if the resident is a private payer.
 - p. **Proposed Living Arrangement (if known):** Select proposed living arrangement. If "Other" is selected. Describe on line provided.
 - q. **Months institutionalized and admit date to institution.** Enter the months that the resident has been institutionalized at the referring facility. Enter the date that they were admitted. If there is more than one facility that they have been institutionalized at, complete "more than one facility" section as appropriate.

2. The Local Contact Agency to complete the following:

Follow-Up-Local Contact Agency (LCA) to enter the Name/Agency of LCA representative, the date the LCA representative contact the resident/family, the date the LCA representative met with the resident/family and the date the referral form was returned to the facility.

Upon completion of this form, The referring facility to send the DHS 1132A, Facility Face Sheet and Current DHS 1147 form to the Going Home Plus Representative:

Madi Silverman-Going Home Plus-Local Contact Agency

Phone: 808-692-8166

FAX: 808-692-8087

Mail: P.O. Box 700190 Kapolei, HI 96709-0190