INTAKE FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date of Referral: ___/___/___
Region: _____

Referral #: _____
(Date YYYYMMDD + Region number +R + referral counter, Ex. 20061015-02-R012)

Applicant Name: ☐ Mr. ☐ Mrs. ☐ Ms _____
(First/MI/Last/Generational Suffixes)

Date Contacted : ___/___/___ Date Intake Scheduled for: ___/___/___ Final Intake Date:___/____/___

Applicant Information

Current Telephone: (___) _____

Current Location:
☐ Private Residence ☐ Hospital ☐ Physical Rehabilitation Facility ☐ Psychiatric Facility
☐ Nursing Home ☐ Adult Home/Assisted Living ☐ Substance Abuse Rehab. Facility
☐ Jail/Prison ☐ Other: _____

Location Address: _____
Street City State Zip

Comments: _____

Legal Residence: ☐ same as Current Location Address _____
Street

_____
City County/Region State Zip

Comments: _____

Mailing Address (Please check which one applies): ☐ Current ☐ Legal

Is applicant proficient in English? ☐ Yes ☐ No
Does the applicant need a translator? ☐ Yes ☐ No
If yes, what language? _____

Translation provided by: _____ Telephone: (___) _____

Does applicant need a sign language interpreter? ☐ Yes ☐ No
If yes, interpretation provided by: _____ Telephone: (___) _____

Does applicant require written materials in alternative formats? ☐ Yes ☐ No
Specify: _____

Contact Information

Legal Guardianship ☐Yes ☐ No If yes, obtain documentation.
Legal Guardian Name (if applicable): _____ Telephone: (___) _____
Contact Person Name: _____ Relationship to Applicant: _____

Address: ☐ same as above _____
Street

_____
City State Zip

Telephone: (___) _____

Intake Form (continued)

Applicant Name: **Referral #**

Demographics

Applicant Birth Date: ___/___/_____ Applicant Sex: ☐ Female ☐ Male

Applicant Age:_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity: ☐ Caucasian ☐ Black or African American ☐ Asian ☐ Native American/ Alaskan Native ☐ Hispanic/Latino ☐ Other:_____

Insurance

Medicaid Status: ☐ Active ☐ Pending ☐ Spend down ☐ Needs to Apply CIN:_____ ☐ Denied ☐ Unknown ☐ Managed County of fiscal responsibility:_____

Medicare Status: ☐ Active ☐ A ☐ B ☐ D ☐ Managed ☐ Pending ☐ Denied ☐ Needs to Apply ☐ N/A Medicare #:_____

Veteran: ☐ Yes ☐ No

Other insurance plan:_____

Diagnosis/Needs

Reported Primary Diagnosis:_____

Reported Other Diagnosis:_____

Population category (check all that apply)
☐ Senior (65+) ☐ Physical Disability (18-64) ☐ MR/DD ☐ Mental Illness

Impact on the Individual:
☐ Describe Physical Disabilities:_____

☐ Describe Cognitive Disabilities:_____

☐ Describe Behavioral Concerns:_____

Intake Form (continued)

Applicant Name: **Referral #**

Currently Living With: ☐ Alone ☐ Spouse ☐ Adult Children ☐ Minor Children ☐ Parents ☐ Siblings ☐ Other Family Members ☐ Friends/Significant Others ☐ Other _____

Onset of Needs Occurred Within: ☐ the last 3 months ☐ last 3-6 months ☐ last 6-12 months ☐ last 1-2 years ☐ last 2-5 years ☐ more than 5 years

Expected Needs: ☐ personal care ☐ housekeeping ☐ meals ☐ getting out of bed ☐ supervision for safety reasons ☐ bill paying ☐ home modification ☐ assistive medical equipment ☐ structured social activities ☐ other:_____

Is there help in the home now? ☐ Yes ☐ No

Informal: ☐ Spouse ☐ Adult Children ☐ Minor Children ☐ Parents ☐ Siblings ☐ Other Family Members ☐ Friends/Significant Others ☐ Other:_____

Type of help:_____

Formal: ☐ TBI Waiver ☐ NHTD Waiver ☐ LTHHCP ☐ OMRDD ☐ OMH ☐ State Plan, Please list: _____ ☐ Other:_____

Type of help:_____

Previous experience with NYS HCBS Waivers. ☐ Yes ☐ No If yes, which waiver:

☐ NHTD ☐ TBI ☐ LTHHCP ☐ Care at Home ☐ OMRDD
☐ OMH Children with Serious Emotional Disturbance ☐ Other:_____

Is Applicant: ☐ Diverting from: ☐ In-state ☐ Out of State ☐ Transitioning from: ☐ In-state ☐ Out of State

*Was the applicant going to go to an Out of State facility? ☐ Yes ☐ No

If Transitioning, approximate length of stay in the nursing facility: ☐ under 3 months ☐ 3-6 months ☐ 7-11 months ☐ 1-2 years ☐ over 2 years

Proposed Living Arrangements

Proposed County:_____ Proposed Region:_____

Proposed Address: ☐ same as Current Location above ☐ Unknown

_____
Street City State Zip Code

Intake Form (continued)

Applicant Name:	Referral #

Proposed Living Situation: ☐ Alone ☐ Spouse ☐ Adult Children ☐ Minor Children
☐ Parent ☐ Siblings ☐ Other Family Members
☐ Friends/Significant Others ☐ Unknown ☐ Other: _____

Proposed type of community residence:
☐ Home (owned or leased by individual or family)
☐ Apartment (individual lease, lockable access, etc.)
☐ Group home or other residence in which 4 or fewer unrelated individuals live
☐ Other:_____
☐ Unknown at this time

Intake Status: ☐ Pending Date:_____/_____/_____ ☐ Completed Date:_____/_____/_____

Intake Status

Decision reached Date:____/____/____

☐ Pending

☐ Transfer: Region _____ Date_____
Comments:_____
_____

☐ Proceed to Application

☐ Do not proceed to Application due to:

☐ Level of Care
☐ Age
☐ Not MA eligible
☐ Guardian refused participation
☐ Chose not to apply
☐ Unable to meet for Intake within 60 days of the scheduled date
☐ Other:_____
_____

☐ Notice of Decision – Denial of Waiver Program – Issued NOD Date: _____/_____/_____
Date DOH WMS notified: _/_____/_____

Intake Form (continued)

Applicant Name:	Referral #

Referral made to other resource(s):

☐ Point of Entry ☐ TBI Waiver ☐ NHTD Waiver ☐ LTHHCP
☐ OMH ☐ OMRDD ☐ Consumer Directed/PCS
☐ CHHA ☐ Office for the Aging
☐ None ☐ Other _____

Forms Checklist

☐ Initial Applicant Interview Acknowledgement Date: _____/_____/_____

☐ Freedom of Choice Date: _____/_____/_____

☐ Application for Participation Date: _____/_____/_____

☐ Service Coordinator Selection Sent Date: _____/_____/_____ Accepted date:____/____/____

Service Coordination Agency Name:_____

Existing PRI/SCREEN: ☐ Yes ☐ No Completed: ____/___/___ Expires: ____/____/____
(90 days from PRI Date)

Location of PRI/SCREEN, comments:_____

Indicates nursing home level of care? ☐ Yes ☐ No

Areas of Concern: ☐ Diagnosis ☐ Housing ☐ Level of care determination
☐ Medicaid status ☐ Intensity of support/service needs

Comments:_____

_____

_____

Date sent to Service Coordinator Agency ____/____/_____

Potential MFP Demonstration candidate ☐ Yes ☐ No

Intake completed by:_____
(Signature) (Title)

Contact Sheet/Comments

Signature:_____ Date: _____