rev 4.2.24

DMHAS Nursing Home Diversion and Transition Program

# REQUEST for DIVERSION NURSE SERVICES

Date of Request: _____ Client Name: _____ DOB ___/___/____

Insurance: ☐ No or list Medicaid (ID#_____) Medicare (ID#_____)

Other Insurance: _____ SS# _____

Conservator: ☐ No ☐COP ☐ COE ☐ Both COP/COE Name/Number: _____

Current Client Address:_____ Telephone: _____

Diagnosis: _____

Does the Client AND Conservator consent to this referral request? YES _____ NO _____ (client /COP must be informed prior to receiving Diversion Nurse Services)

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**TYPE OF REQUEST**

☐ **MFP Client** (check one below to identify status) Name of current facility: _____

- ☐ Expected to transition to a HCBS waiver: Specify Waiver _____
  Anticipated Transition Date _____
- ☐ Expected to transition to State Plan Services: Anticipated Transition Date _____
  Address:_____ Telephone: _____
- ☐ Client's transition status is unclear
- ☐ Other: Require consultation to establish plan _____

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☐ **Non-MFP Client** (resides in community already)

Is client on a Waiver ☐ yes ☐ no If yes, which one: _____

Community Supports/involved family or friend? ☐ yes ☐ no If yes, please provide name, contact number, and type of involvement: _____

**Reason for Request** (What do you want the Diversion Nurse to do? Please be SPECIFIC)

**Current Providers**

Mental Health: _____

_____

Medical Providers: _____

_____

_____

**********PLEASE PRINT ONLY IN NEXT SECTION**********

Person Making Request _____ Relationship _____

From _____

(name of agency; hospital; address)

Telephone _____ Email _____

**Fax completed form to the Program Manager or Admin. Assistant (Mary Ives)**
**at fax number (860) 262-5852 or via email at MHW-DMHAS@ct.gov**