DMHAS Mental Health Waiver Request Form

*Request from provider **MUST** include psycho social history, functional assessment or current recovery plan.*

Fax form and clinical information to (860) 262-5852

Nursing Facility ☐ Community ☐

Name: _____ IMD* ☐: CVH ☐ CMHC ☐ GBMHC ☐

Address _____

City _____ Zip code _____

Phone # _____ Primary Language: _____ Secondary: _____

Date of Birth: _____ ☐Single ☐Married ☐Divorced ☐Widowed

Medicaid ID # _____ Social Security # _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ other:_____

Mental Health Diagnosis (DSM V or ICD 10 code): _____

Psychosocial history attached ☐ Functional Assessment attached ☐ Current plan of care attached ☐

Referral Source Agency: _____ Phone # _____

Name: _____ Title: _____

Relationship:

☐ Self ☐ Family ☐ Agency _____ ☐Other _____

Conservator of Person: ☐ Yes ☐ No

Name: _____ Telephone # _____

Address _____

City _____ Zip code _____

Currently receiving services from: ☐ Elder Waiver ☐ PCA Waiver ☐ CFC ☐ ABI Waiver

Current Community Providers:

Clinician _____ Phone _____

Agency: _____

Nursing _____ Phone _____

Agency: _____

ADL needs: **(check all that apply)**

☐ Bathing ☐ Dressing

☐ Feeding ☐ Preparing meals

☐ Transfer ☐ Taking medications

☐ Toileting

Cognitive impairment:

☐ Orientation ☐ Planning

☐ Concentration ☐ Judgment

☐ Attention ☐ Memory

☐ Abstract reasoning ☐ Comprehension

_____ _____

Signature of Applicant or Conservator of Person Date

FOR MHW ADMINISTRATIVE USE ONLY			
DDAP ☐ *YES* ☐ *NO*	*ASCEND* ☐ *YES* ☐ *NO*	*DATE LOGGED:*	
CLINICIAN ASSIGNED:		*DATE ASSIGNED:*	

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**IMD referrals MUST include signed Release of Information, signed Informed Consent, and COP decree (if applicable)*