DMHAS Mental Health Waiver

Working for Integration Support and Empowerment

MH WAIVER REQUEST FORM

Name: _____ Nursing Facility: ☐ Community ☐

Address _____

City _____ Zip code _____

Telephone # _____ Cell phone # _____

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

Medicaid ID # _____ Social Security # _____

Referral Source _____ Phone # _____

Relationship:

☐ Self ☐ Family ☐ Agency _____ ☐Other _____

Conservator of Person: ☐ Yes ☐ No

Name: _____ Telephone # _____

Address _____

City _____ Zip code _____

MH Diagnosis: _____

_____

Current Community Providers:

Clinician _____ Phone _____
Agency: _____

Nursing _____ Phone _____
Agency: _____

Other _____ Phone _____
Agency: _____

ADL needs:

☐ Bathing	☐ Dressing	☐ Transfer	☐ Toileting
☐ Feeding	☐ Preparing meals	☐ Taking medications	☐ Ambulation

Cognitive impairment:

☐ Orientation	☐ Concentration	☐ Abstract reasoning	☐ Comprehension
☐ Planning	☐ Judgment	☐ Attention	☐ Memory

_____ _____

Signature of Applicant Date

Request from provider must include psycho social history, functional assessment and current recovery plan

Rev. 07/25/12 Fax form and clinical information to (860) 262-5852