rev 12.18.25

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# _____

Income Source: ☐ SSI-amount ☐ SSDI-amount ☐ Cash Assistance-amount

☐ Other – List Source: and amount

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)

Are there any in-kind supports ☐ yes ☐ no – If yes, specify

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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)

Identification? (check all that apply) ☐ Driver's license ☐ DMV photo ID ☐ DOC ID ☐ SS Card ☐ Passport ☐ birth certificate ☐ Resident Alien Card

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