CTS Initial Referral

Fax To: (601) 359-6294 Attn: CTS
or
Mail to: Division of Medicaid Attn: CTS
550 High Street, Suite 1000
Jackson, MS 39201

Applicant Information

Referral Date_______________

Name__________________________ __________________________ ______ DOB___________________
(Last) (First) (MI)

Phone #________________ SSN #__________________ Medicaid # __________________ Medicare #__________________

Does applicant have a legal representative? ☐Yes ☐No Representative's name ___________________________________

Phone # ____________________ Representatives address ____

If yes, what type of legal relationship?☐Guardian ☐Surrogate ☐Conservator☐Power of Attorney ☐Other___________

Is legal representative aware of referral? ☐Yes ☐No

Facility Information

Name of Facility______________________________________ Phone # __________________ Fax #___________________

Street address________________________ City ________________ County ______________State____ Zip _____________

Facility Contact Person__________________________ Phone #___________________ Fax #_______________________

Email address of facility contact person ____

Admit date to facility __________ Reason for admission ____

____

Diagnoses____

Is applicant currently taking medication? ☐Yes ☐No

Referral Information **(Areas with * leave blank if Facility Contact and Referral information are the same.)**

*Name of person making referral _________________________________*Relationship to applicant__________________

*Street Address________________________*City__________________*County____________*State____*Zip_________

How did referral source hear about Community Transition Services?____

Please attach copy of the following documentation:

____Current Medication Record
____Intake (Physician Admission note)
____Behavioral Notes
____Face Sheet (Admission Record)
____POA Documents (If Applicable)
____Social History (History and Assessment)
____ Current MDS (Quick Print if possible)

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Preferred Living Arrangements

Preferred County of Transition ______________________________

Does the applicant need assistance in identifying housing? ☐Yes ☐No If no, where does the applicant intend to live?(If applicant will be living with family/friend please list name, address, contact number, and relationship.)

____

Has applicant ever tried to transition to community? ☐Yes ☐No

If yes, what circumstances led to reentry into facility?____

____

Waiver Information

Does the applicant potentially qualify for the Elderly and Disabled Waiver (E&D Waiver)? ☐Yes ☐No

DOM USE ONLY:

Date beneficiary/guardian contacted by DOM staff _________________________

Has a PAS Level I been conducted? ☐Yes ☐No Has a Level II been conducted? ☐Yes ☐No

List any previous waiver/CMHC services____

Initial eligibility requirements met?

☐90 long term care days in facility ☐One day Medicaid Paid ☐Potentially HCBS eligible ☐Indication of moving to a qualified residence

If no, other options discussed/referrals made ____

____

CTS provider selected? ☐Yes ☐No If yes, provider name ____

Reviewed by _____________________________________ _______________
Signature Date

_____________________________________ _______________
Signature Date